RECOMMENDATIONS FOR THE USAID/GUYANA HIV/AIDS STRATEGIC PLAN 2004–2008

Prepared by

Jay Parsons, Team Leader, Synergy Consultant
Mary Freyder, USAID/Washington
Ruth Hope, Synergy Senior Technical Specialist
Charles Johnson, Synergy Consultant
Sangita Patel, USAID/Washington

Submitted to

U.S. Agency for International Development
Georgetown, Guyana

Submitted by

The Synergy Project
TvT Global Health and Development Strategies,
A division of Social & Scientific Systems, Inc.
1101 Vermont Avenue, NW, Suite 900
Washington, DC 20005
Telephone: (202) 842-2939
Fax: (202) 842-7646

USAID Contract: HRN-C-00-99-0005-00

July 2003

Procurement Sensitive Information

EXECUTIVE SUMMARY

There is a critical lack of reliable data to accurately describe the HIV/AIDS epidemic in Guyana. The true extent of the problem is unknown; AIDS case reporting is incomplete, with an estimated 60 percent of cases not reported, and seroprevalence data are outdated. The private sector contributes significantly to the underreporting. Because the Indo-Guyanese community is more likely to consult private practitioners, this contributes to an erroneous belief that HIV/AIDS is an Afro-Guyanese problem.

The epidemic is generalized, with a relatively low prevalence, and by the end of 2001, 2,185 cases had been reported. Females account for 38 percent of all AIDS cases, and in the 15–24 age group significantly more females than males have AIDS. The largest number of AIDS cases is reported in the 20–49 age group, peaking in the 30–34 age group. Because of stigma and discrimination, few Guyanese are willing to be tested for HIV. One of the consequences is that the mean age of survival between diagnosis and death is 4.5 months.

Region 4, which includes the capital, Georgetown, has 80 percent of reported AIDS cases and a prevalence rate of 144.8 per 10,000 people.

The Ministry of Health reported limited data for 2002, indicating HIV prevalence rates of zero to 8.0 percent among pregnant women in Regions 4 and 6; 15.1 percent among men, and 12.0 percent among women seeking treatment for a sexually transmitted infection at the genitourinary medicine clinic in Georgetown. In 2001, seroprevalence among blood donors was reported to be 1.0 percent

Few seroprevalence data are available on for the most-at-risk populations in Guyana. A 1997 study of female commercial sex workers in Georgetown found a 45.0 percent HIV seroprevalence; a 2000 study found a rate of 31.0 percent. However, the two sets of data came from two different ad hoc studies with different sampling frames. A 1998 study of miners living in Guyana's interior and away from their families found a seroprevalence of 6.3 percent. Data do not exist for male and transvestite sex workers, or for men who have sex with men. HIV prevalence in patients with tuberculosis (TB) was 30 percent–41 percent in 2000–2001. Injecting drug use is not believed to be a significant problem in Guyana.

The Government of Guyana recognizes that the HIV/AIDS situation constitutes a serious development and security problem, as well as a public health crisis. The Guyana National Strategic Plan for HIV/AIDS 2002–2006 was developed following a review of the implementation of the National Strategic Plan for HIV/AIDS 1999–2001. The latter plan was flawed by insufficient human, technological, and financial resources; a limited multisector response; lack of a plan to reduce stigma and discrimination against HIV-infected people; and by restricted geographic coverage.

An analysis of the needs and opportunities in HIV/AIDS prevention, treatment, care and support in Guyana yielded four general areas of concern: 1) Policy, coordination, and

management; including surveillance, multisector coordination and planning, and increased capacity for advocacy. 2) Risk reduction by the most vulnerable populations, including behavior change interventions for risk reduction and condom social marketing. 3) Prevention and treatment services, including voluntary counseling and testing, prevention of mother to child transmission, antiretroviral therapy, treatment for opportunistic infections, and human resources in health. 4) Community-based care and support both for people living with HIV/AIDS and for orphans and other vulnerable children.

These recommendations for the USAID strategic plan were developed from an analysis of the needs and opportunities for addressing HIV/AIDS, recognizing that Guyana has a relatively low HIV prevalence and a generalized epidemic. As such, Guyana requires a targeted intervention approach along with interventions to reduce stigma in order to achieve the greatest impact on the epidemic. Although there is a paucity of hard data, international epidemiological evidence suggests that the most-at-risk populations who contribute disproportionately to the growth of Guyana's epidemic include male and female commercial sex workers, minibus drivers and conductors, and itinerant workers or others separated from their wives and regular partners such as miners, loggers, and farmers.

Guyana's healthcare system is characterized by weaknesses in management information systems, procurement, logistics and supplies of essential drugs and commodities. Imbalances exist in staffing between Georgetown and the coastal communities, and the interior regions. Importantly, a large proportion of health sector posts are unfilled. Although facility-based mother and child health services are adequate, there is no community-based infrastructure or outreach to vulnerable populations not well served by static health facilities. The result is poor access to healthcare by highly vulnerable populations.

USAID/Guyana has been working to develop the capacity of youth-focused nongovernmental organizations (NGOs) individually and as members of a network of NGOs. These NGOs still have limited ability to reach the most vulnerable populations. A few, however, have begun to respond, but their ability to do so needs considerable continued strengthening. In addition, communities, community-based organizations, and faith-based organizations have not been mobilized to respond to the HIV epidemic. Voices for the needs and rights of people living with HIV/AIDS are only just being raised, and stigma is a major problem.

Because 80 percent of pregnant women use antenatal care services provided by the Ministry of Health, USAID/Guyana has identified the mother and child health program and the 15-month prevention of mother to child transmission (PMTCT) eight-site pilot as an opportunity to expand PMTCT services in Guyana. Without USAID support, PMTCT services likely will remain limited. The USAID/Guyana program will focus on reducing risky behaviors by the most vulnerable populations and seropositive people who enter the healthcare system through targeted prevention and treatment services such as voluntary counseling and testing and PMTCT, funded through the President's International Mother

and Child HIV Prevention Initiative. With additional funding, it will be possible to expand treatment, and care and support services for people living with HIV/AIDS and their families by providing additional technical support and by improving the capacity of the decentralized health system, and of NGOs and their partner community- and faith-based organizations.

USAID/Guyana is unusual in having an HIV/AIDS strategic objective while not having a related health result for 2004–2008. The HIV/AIDS strategic objective could capitalize on opportunities afforded from the economic growth and democracy and governance strategic objectives in line with requests from the Mission director. In general, the aim of USAID/Guyana is to support and strengthen the implementation of the Guyanese National Strategic Plan for HIV/AIDS, yet a need exists to focus USAID support to implement the national strategic plan to areas of USAID's competitive advantage where maximum impact can be achieved within the life of the USAID/Guyana Strategic Plan for 2004–2008. With limited funds for prevention, the strategic plan must focus on reducing transmission in populations that have highest transmission rates of HIV infection while stabilizing transmission in the wider population.

Funding through the President's International Mother and Child HIV Prevention Initiative will be directed to expanding voluntary counseling and testing services and efforts to prevent mother-to-child transmission. If additional funding becomes available, treatment, care, and support activities will be added. For maximum effect, these activities will be clustered with both the enhanced Ministry of Health services and systems for voluntary counseling and testing and prevention of mother-to-child transmission; through stronger nongovernmental, community, and faith-based organizations; and via peer counselors who work to promote behavior change, reduce the stigma associated with HIV/AIDS, and increase the demand for services.

These considerations lead to the formulation of the strategic objective as: **HIV transmission reduced and the impact of AIDS mitigated.** USAID/Guyana will report HIV seroprevalence rates among commercial sex workers and the number of HIV-infected women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission.

An analysis of the needs and opportunities in prevention, treatment, care and support has resulted in the identification of four intermediate results (IRs) to achieve this strategic objective. The first is **IR1: Improved policy, coordination, and management.** This will be achieved by 1) enhancing the capacity and quality of Government of Guyana HIV surveillance systems and their use in decision-making; 2) strengthening the capacity for advocacy; and 3) strengthening multisector coordination and planning, including its integration with the democracy and governance and economic growth strategic objectives.

The most effective means of reducing the transmission of HIV is through **IR2: Increased use of risk-reduction practices by the most vulnerable populations.** Contributing to the achievement of this intermediate result are 1) improving and expanding behavior

change interventions; 2) facilitating community dialogue and action among nongovernmental, community, and faith-based organizations and others; and 3) making condoms available and acceptable.

Because Guyana will benefit from the President's International Mother and Child HIV Prevention Initiative and the President's Emergency Plan for AIDS Relief, a third intermediate result that contributes to SO3 must reflect interventions to prevent mother-to-child transmission and other interventions for treating people living with HIV/AIDS, with the result being **IR3: Increased use of prevention and treatment services.** Illustrative interventions for achieving this intermediate result include 1) expanding access to VCT Plus services; 2) expanding access to PMTCT Plus; 3) expanding access to antiretroviral therapy and treatment for opportunistic infections; and 4) expanding and strengthening human resources to address general health issues and HIV/AIDS.

Part of an effective local response to HIV is to provide care and support to mitigate the effects of HIV infection on people living with HIV/AIDS and to provide for the needs of orphans and vulnerable children affected by AIDS leads to **IR4: Increased use of community-based care and support services.** Two interventions are designed to achieve IR4: a greater capacity for a comprehensive, community-based response to the needs of people living with HIV/AIDS, and to the needs of orphans and vulnerable children.

Proposed Budget. USAID/Guyana expects to receive a total of $18.8 million over the five-year, 2004–2008 period. The illustrative expenditure budget is summarized on the next page.

Component	2004	2005	2006	2007	2008	Total	Percent
BCI, including condom social marketing	650,000	730,000	770,000	1,100,000	1,1500,000	4,400,000	23%
NGO Capacity Building	300,000	300,000	300,000	460,000	400,000	1,810,000	10%
Surveillance: Mapping	250,000	0	0	0	0	250,000	6%
Surveillance: DHS	0	300,000	0	0	0	300,000	
Surveillance: BSS	0	0	250,000	0	250,000	500,000	
Care and support	150,000	200,000	400,000	450,000	500,000	1,700,000	9%
Advocacy Coordination, Multisector response	150,000	200,000	200,000	200,000	200,000	950,000	6%
Monitoring and Evaluation	115,000* 100,000	115,000* 100,000	115,000* 100,000	115,000* 100,000	115,000* 100,000	575,000* 500,000	6%
VCT Plus	300,000	270,000	330,000	390,000	300,000	1,590,000	8%
PMTCT Plus	935,000*	935,000*	935,000*	935,000*	985,000*	4,725,000*	25%
Program Management							
JHU Fellow	200,000*	200,000*	200,000*	200,000*	200,000*	1,000,000*	
Prog. Ass't, overhead	100,000	100,000	100,000	100,000	100,000	500,000	8%
Total PMTCT*	1,250,000*	1,250,000*	1,250,000*	1,250,000*	1,300,000*	6,300,000*	
Total Other HIV/AIDS	2,000,000	2,200,000	2,500,000	2,800,000	3,000,000	12,500,000	
GRAND TOTAL	3,250,000	3,450,000	3,750,000	4,050,000	4,300,000	18,800,000	100%

Note: Presidential Initiative funds (noted with *) for prevention of mother-to-child transmission (PMTCT) activities totaling $6.3 million are planned for this strategic objective; $2.5 million will be obligated in 2003 and $3.8 million (estimated) in FY 2004. However, for comparability in planning with other HIV/AIDS funds, the PMTCT funds are identified on an annual basis on the basis of when they will be expended rather than when they will be allocated or obligated. The total figure of $6.3 million is an estimate derived from original guidance and is used for planning purposes.

ABBREVIATIONS

AIDS	Acquired immunodeficiency syndrome
BCI	Behavioral change interventions
BSS	Behavioral surveillance survey
CAREC	Caribbean Epidemiological Center
CBO	Community-based organizations
CDC	United States Centers for Disease Control and Prevention
FBO	Faith-based organization
FY	Fiscal Year
G+	Network of Guyanese Living with HIV/AIDS
GDP	Gross Domestic Product
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GTZ	German Agency for Technical Cooperation
HIV	Human immunodeficiency virus
IR	Intermediate Result
NGO	Nongovernmental organization
OHA	Office of HIV/AIDS – USAID Washington
OI	Opportunistic infection
OVC	Orphans and other vulnerable children
PMTCT	Prevention of mother to child transmission
PSI	Population Services International
SO	Strategic Objective
STD	Sexually transmitted disease
STI	Sexually transmitted infection
TAACS	Technical Advisors in AIDS and Child Survival
TB	Tuberculosis
UNAIDS	United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing
WHO	World Health Organization

MAP OF GUYANA

Contents

I. INTRODUCTION

In May 2003, a five-person team—two members from the USAID Office of HIV/AIDS, a Synergy Project senior technical specialist, and two Synergy Project consultants—worked with the USAID/Guyana Mission and consulted partners to prepare a strategic framework for HIV/AIDS. This framework is the basis of these recommendations for the USAID/Guyana Strategic Plan for HIV/AIDS for FY 2004–2008.

The team held stakeholder meetings with the Mission and its economic growth and democracy and governance strategic design teams, representatives of government and nongovernmental organizations (NGOs), and bilateral and multilateral donors working in Guyana. Focus group discussions with the nine NGOs involved in the present HIV/AIDS special objective were conducted both in Georgetown and in three field locations. Strategic planning meetings were held with the USAID/Guyana HIV/AIDS advisor to develop the strategic framework.

II. COUNTRY SITUATION

A. Guyana Situational Analysis

Guyana, the only English-speaking country in South America, identifies culturally with the English-speaking Caribbean. It is a member of the Caribbean Community, and the Commonwealth, and receives technical assistance from the Caribbean Epidemiology Centre (CAREC). Guyana has a multiparty democracy with a Westminster-type parliament; the executive president is head of parliament and state.

Although Guyana is rich in oil and minerals, it is one of the poorest countries in the western hemisphere. Guyana is ranked 96th on the United Nations Development Programme's Human Development Index, with a per capita GDP of US$597 in 2000,[1] the lowest in the English-speaking Caribbean. Guyana's debt burden is among the highest globally, and it qualified under the Heavily Indebted Poor Countries Initiative in 1997.[2] The government juggles its debt against the urgent need for public investment to address a deficient infrastructure. Chronic problems include a shortage of skilled labor with outward migration of skilled and professional staffs. Guyana launched an economic recovery program in 1988 and achieved growth in excess of 7 percent between 1991 and 1997. Since then, the economy has stagnated.[3] A 1999 survey found that 36.3 percent of the population lives below the poverty line, with Amerindians recording the highest level of poverty.[4] Eighty-eight percent of Amerindian households live below the poverty line.[5]

[1] United Nations Development Programme, 2002.

[2] Ministry of Health; 2002b.

[3] Guyana Country Coordinating Mechanism, 2003.

[4] Pan American Health Organization, 2001.

[5] National Commission on Women, November 1997.

The population of Guyana is multiethnic. Indo-Guyanese constitute 50 percent of the population; other ethnic groups include Afro-Guyanese (36 percent), Amerindians (7 percent) and Chinese (7 percent).[6] The different ethnic groups came to Guyana under vastly different circumstances—the Afro-Guyanese came in the 18th century as slaves, whereas Indo-Guyanese arrived in the 19th century as indentured laborers. These differences brokered by colonial masters may underscore current socioeconomic differences between the communities, and political tensions. Afro-Guyanese people are more likely to farm and work in the informal economy, or in the public and uniformed services, while Indo-Guyanese are more likely to own businesses or, if they are medically qualified, to be in private medical practice.

Population growth from 1975 to 1998 was 0.6 percent.[7] The estimated total population in June 2002 was 698,209.[8] Life expectancy at birth is 65 years (62 for men and 68 for women). In 1998, the most recent date for which information is available, the maternal mortality ratio was 125 per 100,000 live births, and the infant mortality rate was 23 per 1,000 live births. The total fertility rate is 2.0. External migration plays an important role in Guyana's demographics. During the 1996–1999 period, more than 56,000 people left the country.[9] Approximately 30 percent of the population is under age 15, and 9 percent of the population is younger than 5. Nearly 7 percent of the population is older than 60 years.[10]

Guyana is divided into 10 regions, each managed by a regional democratic council that is administratively responsible for delivering public services, including health services, within its boundaries. However, the Ministry of Health retains responsibility for the vertical health programs, including those for AIDS, throughout the country.[11] The government is currently engaged in a significant restructuring the public health services with greater decentralization and autonomy. The intention is that health service delivery will be concentrated in four health service management committees that will have authority over human and financial resources.

Georgetown Public Hospital has already become a semi-independent corporation, but some officials have expressed concern that the hospital is minimizing its costs rather than maximizing public benefits. Services remain free at the point of access.[12] Important issues include quality of care, inadequate information systems and reporting, and major problems with staffing, with vacancy rates of 25 percent to 50 percent in most categories. Vacancy rates are higher in rural areas, and in some specializations: for example, almost 70 percent of all physicians practice in Georgetown, which is home to one-quarter of the

[6] Central Intelligence Agency, 2002.

[7] Ministry of Health, 2002b.

[8] Central Intelligence Agency, 2002.

[9] Pan American Health Organization, 2001.

[10] Ministry of Health, 2002b.

[11] Pan American Health Organization, 2001.

[12] Ministry of Health, 2002b.

population.[13] The private sector has been expanding rapidly and provides about half of all curative services. Most of these services are provided in the capital city and other urban centers. Several NGOs, including religious organizations, provide services on a not-for-profit basis. Financing in the private sector is through fees from individual patients. There is no formal relationship among the various actors in the private sector.[14]

Of all the health conditions associated with HIV/AIDS, sexually transmitted infections are common, including ulcerating infections such as chancroid and syphilis. However, few data exist because treatment even at the national genitourinary medicine clinic is syndromic, and private practitioners treat many infections. The incidence of tuberculosis has been rising since 1992. This is attributed to HIV/AIDS, poverty, and urban overcrowding, as well as increased transmission due to lack of treatment completion by patients.[15]

Very little is known about local practices and behaviors that fuel the HIV/AIDS epidemic. A study by Family Health International of 754 Guyanese youth from Georgetown, New Amsterdam, and Linden[16] found that the average age of first sex is 15 years, with ages ranging from a low of 3 (one respondent) to a high of 23. Twenty-five respondents (3.2 percent) reported having had first sex at age 10 years or younger, and 8.9 percent of the sample reported having had first sex when they were younger than 12 years. Approximately 66 percent of those who had already had sex had unprotected sex the first time.

Focus group discussions[17] elicited that boys force their girlfriends to have anal sex because it is considered safe, but young women do not really like it. Because some youth do not perceive anal intercourse as sex, they do not believe that HIV can be transmitted this way. Injecting drug use is said not to be a problem but little is known about the use of cannabis, cocaine, and even alcohol in relation to sexually risky behaviors of all sexually active age groups. One informant averred that women in the Georgetown Jail are a highly vulnerable group because many are remanded in jail for being "drug mules" (i.e., women who carry illicit drugs for traffickers both internationally and locally). These women may have been sexually abused—raped or gang raped to humiliate them into carrying drugs—or have had transactional sex in exchange for money or cocaine.[18]

Focus groups within the Hindu Indo-Guyanese community revealed problems with alcoholism, domestic violence, suicide, rape, and incest. Teen pregnancies are not viewed as a problem because abortion is readily available from private practitioners.[19] At the present, the NGOs with which USAID's HIV/AIDS/STI Youth Project works have limited reach into the Indo-Guyanese population.

---

[13] Pan America Health Organization, 2001.

[14] Pan America Health Organization, 2001.

[15] Pan America Health Organization, 2001.

[16] Family Health International, undated.

[17] Focus group meetings with Indo-Guyanese youth, Industry Village, May 10, 2003.

[18] Interview with Bonita Harris, peer education resource person, May 9, 2003.

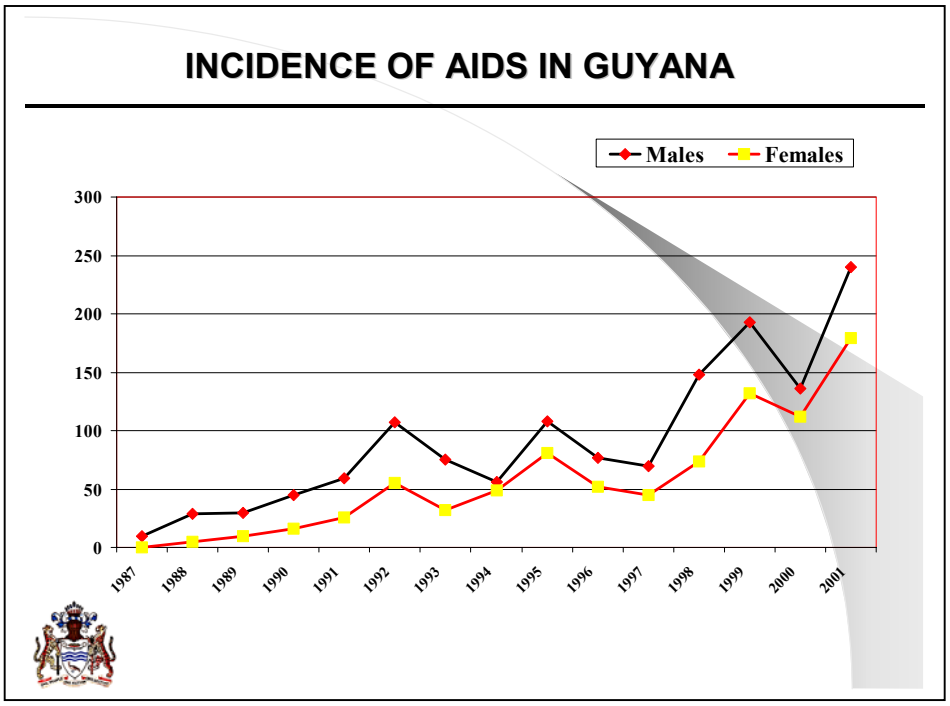
[19] Focus group meetings with male and female Indo-Guyanese youth, Industry Village, May 10, 2003

B. Current Status of the Epidemic

There is a critical lack of reliable data to accurately describe the HIV/AIDS epidemic in Guyana. The true extent of the problem is unknown because AIDS case reporting data are incomplete, with up to an estimated 60 percent underreporting, and seroprevalence data outdated.[20] The private sector contributes significantly to the underreporting and, additionally, death certificates prepared by private physicians seldom indicate mortality related to AIDS. Because the Indo-Guyanese community is more likely to consult private practitioners, this contributes to an erroneous belief that HIV/AIDS is an Afro-Guyanese problem.[21]

Figure 1.

[Courtesy of Dr. Navindra Persaud]



The first case of AIDS in Guyana was diagnosed in 1987. There has been a progressive increase in reported AIDS cases since that time, with a significant increase between 1997 and 1998, and a further sharp increase in 2001 over 2000. The epidemic has become generalized among the population, and by the end of 2001, 2,185 cases had been reported. Females now make up 38 percent of all AIDS cases and significantly more females than males in the 15–24 age groups have AIDS.[22] In general, the largest number of AIDS cases is reported in the 20–49 age group, peaking in the 30–34 age group. Because of stigma and discrimination, few Guyanese are willing to be tested for HIV. One of the consequences is that the mean

[20] Ministry of Health, 2002a.

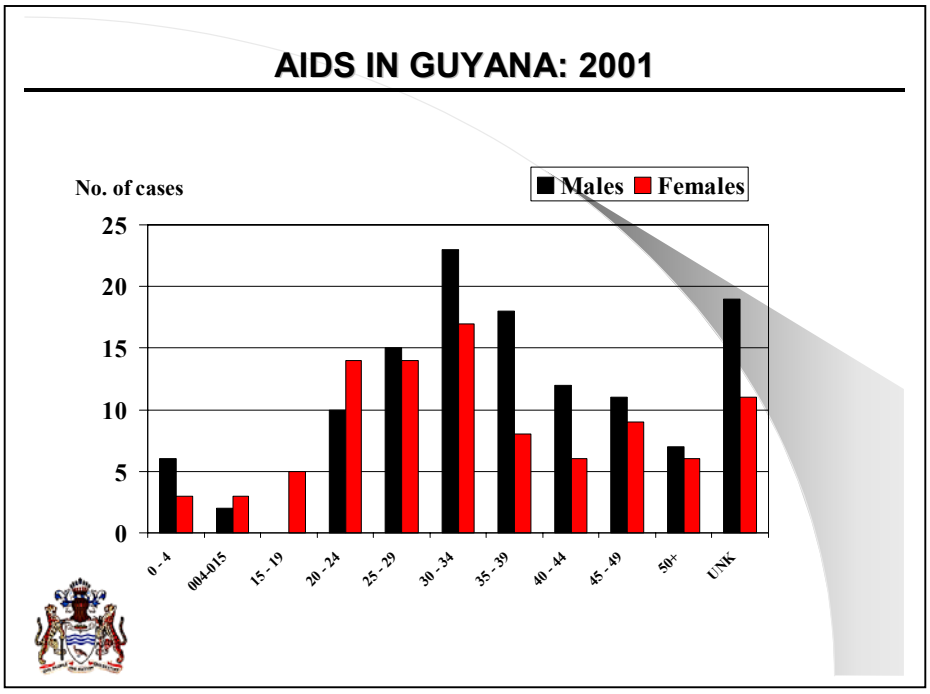
[21] Personal communication with Leslie Ramsammy, Minister of Health, May 7, 2003.

[22] M. Edwards et al., 2003.

age of survival between diagnosis and death is 4.5 months.[23]

Figure 2.

[Courtesy of Dr. Navindra Persaud]



Using data from 2000, 80 percent of reported AIDS cases occurred in Region 4, and 6 percent each occurred in Regions 6 and 10. These are the coastal regions where the majority of the population of Guyana resides. The prevalence rate for Region 4—which includes the capital city, Georgetown—is 144.8 per 10,000 people. For Region 6 the reported prevalence is 25.9 per 10,000 people, and for Region 10 it is 86.6 per 10,000. Region 3 has a reported AIDS prevalence of 33.8 per 10,000 and the other, far more sparsely populated regions in the interior report lower rates.[24]

Seroprevalence in blood donors was reported to be 1.0 percent in 2001. The National Laboratory for Infectious Disease tests all donated blood and blood products, and samples sent to CAREC in Trinidad for quality control. There has been one highly publicized case in which a mother claimed her daughter contracted HIV through a blood transfusion. Although there was no way of proving this, the government assumed responsibility of providing antiretroviral therapy for the girl. This case has caused a considerable mistrust in the community regarding the safety of donated blood. No studies have been conducted of possible health service contributions to the spread of HIV—for example, through the reuse of contaminated needles, syringes, and other equipment.

[23] Ministry of Health, 2002a.

[24] Ministry of Health, 2002a.

The Ministry of Health reports[25] that data for 2000 indicate HIV prevalence rates of

- 0 percent–8.0 percent among pregnant women in Regions 4 and 6;
- 15.1 percent among male patients at the genitourinary medicine clinic; and
- 12.0 percent among female patients at the genitourinary medicine clinic.

In addition, a Pan American Health Organization report[26] for 2000/2001 indicated an HIV prevalence rate of 30 percent to 41 percent in patients with tuberculosis.

A 1997 study of female commercial sex workers found an HIV prevalence rate of 45 percent,[27] and a 2000 study found a seroprevalence of 31 percent.[28] However, data on HIV prevalence in female sex workers comes from ad hoc studies with different sampling frames among different groups of female sex workers, so trends cannot be determined. Data do not exist for male sex workers, transvestite sex workers, and men who have sex with men.

A 1998 study of miners, a mobile population of men living in the interior of Guyana away from their families, found a prevalence of 6.3 percent.[29] Injecting drug use is not believed to be a significant problem in Guyana.

C. Government of Guyana Response

The Government of Guyana has recognized for some time that the HIV/AIDS situation constitutes a serious development problem as well as a public health crisis. The Guyanese National Strategic Plan for HIV/AIDS for 2002–2006 was developed and approved following a review of the implementation of the National Strategic Plan for HIV/AIDS 1999–2001. National consultations sought input from a cross section of government ministry officials, NGOs, lawyers, representatives of people living with HIV/AIDS, faith-based organizations (FBOs), United Nations organizations, and international and bilateral donor agencies. The comprehensive 1999–2001 plan was limited in its implementation by insufficient human, technological, and financial resources; a limited multisector response; stigma and discrimination against HIV-infected persons; and restricted geographical coverage.[30]

A national program began to emerge in 1989 with the establishment of the genitourinary medicine clinic in Georgetown, the National Laboratory for Infectious Disease, the National Blood Transfusion Service, and the National AIDS Programme. The National AIDS Committee was also constituted in 1989. By1992 the National AIDS Programme Secretariat was established and working under its medium-term plan for 1992–1997.

---

[25] Ministry of Health, 2002a.

[26] Pan America Health Organization, 2001.

[27] Pan America Health Organization, 2001.

[28] C. Allen, 2000.

[29] C.J. Palmer et al., 2002.

[30] Ministry of Health, 2002a.

A program for increasing access to voluntary counseling and testing (VCT)—a key element in the medium-term plan—was developed in collaboration with the CAREC and the German Agency for Technical Cooperation (GTZ).

A program to prevent mother-to-child transmission (PMTCT) of HIV began in 2001 and expanded in 2002 to eight pilot sites. The program offers HIV and hepatitis B testing and nevirapine for mother and infant, and nutrition counseling and replacement infant feeds for 18 months. Some 81 staff members have been trained in pretest and posttest counseling, and 154 nurses have been trained in infant feeding counseling. A PMTCT manual and video have been produced. The hiring of phlebotomists has somewhat enhanced the laboratory service. Some implementation difficulties including shortages of infant formula for replacement feeds, delayed availability of test results, and transportation for the phlebotomists.[31]

The Government of Guyana has responded to HIV/AIDS in the workplace. In collaboration with the Occupational Safety and Health Department of the Ministry of Labor, occupational safety officers from public and private enterprises received awareness training and begun sensitizing employees to HIV/AIDS at their work sites. AIDS awareness and education training was conducted in 600 workplaces in 2001, reaching nearly 14,000 employees.

The government has encouraged and supported a considerable amount of targeted public education with an emphasis on raising awareness, education about the cause of AIDS, the spread of HIV infection, and prevention of infection.[32] Sensitization has focused on healthcare providers, youth, employers/employees, entertainers, and commercial sex workers. A media initiative for responsible journalism has been undertaken.

Finally, treatment with antiretroviral therapy was made available free of charge to HIV-positive patients showing signs of one opportunistic infection, through the genitourinary medicine clinic, beginning in 2002.

D. History of USAID Assistance

Until 2000, USAID/Guyana supported activities primarily in the areas of economic growth and democracy and governance. In June 1999, two consultants completed a rapid assessment of the HIV/AIDS situation in Guyana. Their report concluded that, given the rapid spread of HIV/AIDS in Guyana, USAID should include support for HIV/AIDS in its Mission strategy. The report recommended that the initial effort should concentrate on prevention activities. Given the known weaknesses within the Ministry of Health, general consensus was that USAID should work through NGOs. A special objective—"Improved HIV/AIDS Knowledge and Prevention Strategies"—was approved in 2000 and aimed at increasing Guyana's prevention efforts and slowing the rate of new infections. An amount of $200,000 was allocated in FY 2000. Major activities included:

[31] D. Vitalis, 2003.

[32] Ministry of Health, 2002a.

- An HIV/AIDS/STI Youth Project implemented through nine local, youth-orientated NGOs;
- A healthy youth initiative with the Ministry of Health to address the growing number and severity of health-related issues affecting youth;
- Commodity logistics support to the Ministry of Health with technical assistance of the Deliver project managed by John Snow, Inc.;
- A social marketing program focusing on behavioral change interventions to delay initial sexual activity or to continue abstinence, partner reduction, and condom social marketing through Population Services International;
- Strengthening voluntary counseling and testing services by providing technical assistance to the Youth Project NGOs to create care and support programs and expand services to include voluntary counseling and testing.

Funding for the special objective has grown rapidly from the initial $200,000 in FY 2000, to $800,000 in FY 2001, to $1,500,000 in FY 2002, and to $1,700,000 in FY 2003. Guyana is one of 14 countries included in President Bush's International Mother and Child HIV Prevention Initiative, with funding of $2,100,000 for FY 2003. In FY 2004, the International Mother and Child HIV Prevention Initiative will become a component of the President's Emergency Plan for AIDS Relief.[33]

E. Other International Assistance

Between 1988 and 2000 the Government of Guyana was the main source of financial support for HIV/AIDS programs. Since then, external funding has surpassed domestic sources of funding by approximately 50 percent.[34] USAID continues to be the largest source of financial and technical assistance to the national program.

Table 1 matches other international donors with their areas of HIV/AIDS assistance.

[33] A. Gibbons, 2003.

[34] Republic of Guyana, undated.

Table 1: Foreign Donor Assistance to HIV/AIDS

Donor	Major Areas of Assistance	Estimated Funding*
Canadian International Development Agency	HIV/AIDS prevention; communicable disease control; Pilot health management information system; stigma and discrimination; DOTS expansion	$3 million 2003–2006
U.S. Centers for Disease Control and Prevention	Laboratory strengthening, treatment, testing, surveillance	$1–3 million Annually
European Union	Strengthen national capacity to respond to HIV/AIDS	Limited
GTZ with Caribbean Epidemiological Centre	Technical support for VCT surveillance; HIV/AIDS and STI prevention; HIV prevention among commercial sex workers	Limited
Global Fund to Fight AIDS, TB and Malaria (Proposed)	Multifaceted proposal for HIV/AIDS prevention, treatment, care and support. Training of personnel; management information system; upgrade laboratory capacity and capability; strengthen surveillance systems; quality care for persons living with HIV/AIDS; expand VCT; reduce stigma and discrimination; condom social marketing	$10–$20 million 2002–2008
Inter-American Development Bank	Support for health sector reform	TBD
Japan International Cooperation Agency	Small grants for HIV/AIDS programs	
Japanese Trust for Human Resource Development/ UNESCO	HIV/AIDS education within public school curriculum	$0.1 million 2003–2004
PAHO/WHO	Technical assistance for HIV/AIDS prevention, TB, and malaria control; small grants scheme management	Ongoing
UNAIDS	Coordinate HIV/AIDS activities of the United Nations Theme Group	Ongoing
UNDP	Chairs UNAIDS Theme Group; limited HIV/AIDS activities	No estimate Ongoing
UNICEF	Healthy Family Life Education program with Ministry of Education; Dutch government support to Linden Care Foundation for work with orphans	$1.6 million 2001–2005
UNFPA- OPEC Fund	Caribbean–Central America project for HIV/AIDS prevention among youth as part of adolescent health program	$0.442 million 2002–2006
U.S. Department of Labor/Int'l. Labor Organization	HIV/AIDS workplace education with Family Health International as the implementing agency	$0.3–$0.4 million 2003–2006
U.S. Peace Corps	20–25 volunteers working in health; 7 currently working with NGOs with expansion possible	No estimate
World Bank	Possible grant for HIV/AIDS program	$6,000,000

*U.S. dollars and funding time period.

F. Needs and Opportunities in Prevention, Treatment, Care and Support

The USAID Strategic Plan for HIV/AIDS in Guyana includes activities that address prevention, treatment, and care and support. In order to better understand the USAID/Guyana response, a presentation of needs and opportunities follows:

1. Policies, Coordination, and Management

a. Surveillance

Currently, available HIV data are not an adequate basis for planning a targeted response to the epidemic. It is difficult to identify the most-at-risk populations and their estimated size; similarly, it is difficult to determine the geographic distribution of HIV infections. As much as 60 percent of AIDS cases are unreported. The Ministry of Health relies on a passive reporting system tracking HIV-positive tests and reported AIDS cases.

A second-generation surveillance system that tracks HIV seroprevalence in the general population as well as most-at-risk populations linked to key behavior surveys[35] needs to be established in Guyana. Case reporting should continue and needs to be strengthened. However, seroprevalence and behavior surveys must complement routine case reporting. Annual HIV surveillance surveys need to be conducted. Population-based household behavioral surveys should be conducted every five years. A mapping exercise is necessary to identify the geographic distribution of high-risk behaviors. Periodic behavioral surveillance surveys with a seroprevalence component are needed to measure trends in risk behaviors of target groups while linking the information with seroprevalence results in order to track core transmitters. USAID/Guyana would like to collaborate with the Centers for Disease Control and Prevention (CDC) and the Ministry of Health in developing these surveillance systems.

A second priority is a national survey of HIV program coverage in Guyana. The AIDS Indicator Survey is currently in development with support from USAID Washington. The survey has two components: a population-based household survey, and a national facility survey. The AIDS Indicator Survey will be a useful tool for assessing program coverage across Guyana.

b. Multisector Coordination and Planning

The national HIV/AIDS plan recognizes the importance of involving a wide array of governmental organizations as well as the private and NGO sectors of Guyanese society, but its implementation remains the responsibility of the Ministry of Health. The National AIDS Committee, which reports to the Ministry of Health, attempts to bring together a multisector group on a quarterly basis, but not all ministries are included. The National AIDS Committee is considered weak, and in practice, its role is not always distinct from that of the National AIDS Programme Secretariat. Apart from the quarterly National

[35] World Health Organization, 2000.

AIDS Committee meetings, there appears to be little multisector coordination at the national level. The Ministry of Labor initiated an HIV/AIDS-in-the-workplace program in 2000, but funding ceased the following year. A three-year program for HIV/AIDS workplace education between the Ministry of Labor and the International Labor Organization, working with Family Health International, and funded by the U.S. Department of Labor, began in May 2003. The Ministry of Culture, Youth and Sports indicated an interest in developing a youth-focused HIV/AIDS activity.[36] With minimal Government of Guyana funding available, involvement of ministries will require donor support, but without leadership from the most senior level—the President's Office—multisector responses are unlikely to happen.

Within the decentralized system, opportunities exist for multisector coordination through the devolved Regional Democratic Councils if there is strong political leadership from the national level. The regional AIDS councils need full-time technical focal persons to work with technical staff members from line ministries to coordinate a multisector response in the regions and to ensure that national policies are implemented regionally.

c. Increased Capacity for Advocacy

The potential danger to Guyana from an increasing HIV/AIDS epidemic has not been addressed in public by the highest levels of government or influential elements of society, such as Hindu, Muslim, and Christian leaders. Although the Guyanese National Strategic Plan for HIV/AIDS addresses the potential epidemic as a national development problem, rather than a health issue, this concept has yet to be internalized within the political, economic, religious, and cultural leadership. The National AIDS Programme Secretariat and the National AIDS Committee represent the government's attempts to respond to the HIV/AIDS epidemic. However, the main advocates for persons infected with or affected by HIV/AIDS are a small group of NGOs that receive funds mainly from USAID. People living with HIV/AIDS have not been mobilized or organized to function in an advocacy role. Advocacy could address a variety of issues affecting people living with HIV/AIDS and their families, including access to counseling, testing, treatment, care and support, workplace discrimination, and community stigma.

There is clear need for advocacy at the highest levels for multisector approaches. In addition, an opportunity exists for the U.S. ambassador to influence thinking through the interagency HIV/AIDS Coordinating Committee, which he chairs. Furthermore, opportunities exist for USAID/Guyana, in its Mission strategic plan, to identify how the economic growth and democracy and governance strategic objectives might best interact to support HIV/AIDS interventions, particularly using a growing network of civic organizations and efforts to expand microenterprises.

[36] Interview with Dr. Gail Teixeira, Minister of Culture, Youth and Sports, May 9, 2003.

2. Risk Reduction by Most Vulnerable Populations

a. Behavior Change Interventions for Risk Reduction

The Guyanese National Strategic Plan for HIV/AIDS emphasizes the adoption of risk-reduction practices by youth and persons in the workplace. The Ministry of Health further endorses the promotion of delayed sexual debut and healthy, monogamous relationships, citing the role that positive family structures and values can play in preventing HIV/AIDS.[37]

USAID efforts to date in Guyana have strengthened NGO capacity to focus on youth with "ABC" messages (i.e., A for abstinence and delayed sexual debut, B for partner reduction, and C for consistent and condom use). However, there continues to be a progressive increase in new HIV infections. Limited seroprevalence data suggest that HIV prevalence in the general population is in the 5 percent to 7.5 percent range, and is much higher among people who practice high-risk behaviors.[38,39,40].

USAID's technical approach to HIV prevention is based on global experience and substantial global epidemiological evidence regarding the trajectory of HIV epidemics. Current epidemiological evidence suggests that the following strategy is appropriate for Guyana. There is need for the USAID/Guyana HIV prevention approach to focus on those most-at-risk populations identified by seroprevalence sentinel surveys. Specifically, concerted efforts are needed to promote attitudinal change to enable people in most-at-risk populations to seek HIV information and services. There is need for USAID/Guyana to strengthen behavior change intervention efforts to strategically cover most-at-risk populations in regions with the greatest burden of HIV/AIDS. Behavioral surveillance surveys and seroprevalence data, once they become available, will guide efforts by NGOs, community-based organizations (CBOs), and faith-based organizations (FBOs) to implement more "B" and "C" intervention messages for the most-at-risk populations, and greater adoption of risk-reduction behaviors and healthcare–seeking practices.

Behavioral change intervention efforts in Guyana must progress beyond current education and awareness efforts that target the general youth population, and shift to a strategic focus that will promote behavioral change by those in the most-at-risk populations and enable them to access available information, products, and health services. Community resources, once they are mobilized, will further facilitate the advocacy needed to reduce stigma, fear, and discrimination, and create the supportive environment necessary for those in the most-at-risk populations to sustain safe behaviors.

b. Condom Social Marketing

The majority of HIV-infected people in Guyana are young, economically active adults, in the 20–34 age group, accounting for 75 percent of the overall total of reported HIV

[37] Ministry of Health, 2002a.

[38] C. Allen, 2000.

[39] Green and Cortez, 2000.

[40] A. Handyside, 2002.

infections. Transmission is primarily heterosexual (80 percent); 18 percent of cases are via by men who have sex with men, and only two reported cases are as a result of injecting drug use.[41]

The Guyanese Strategic Plan for HIV/AIDS and several related studies have indicated the need for a condom social marketing intervention to help slow the transmission of HIV. Currently, about 3 million condoms a year are available for distribution in Guyana, 1.7 million of which are sold by the private sector in mostly urban and periurban areas. The remainder is distributed without charge through the public sector and by NGOs.

Condoms are available in health centers, pharmacies, through a few urban and periurban vending machines supplied by the Ministry of Health, from commercial stores in urban areas, and from NGO-supported peer counselors. Oftentimes, however, condoms are not available when and where they are most needed—at night and in locations frequented by commercial sex workers and their clients. Rural, remote areas seldom have ready access to condoms.

A need exists for a targeted condom social marketing program that would put condoms in the hands of people who engage in high-risk sexual behaviors. In combination with an aggressive mass media communication campaign and peer counseling, a condom social marketing campaign would tend to increase self-risk perception and address misinformation among the most-at-risk populations and the general population about HIV/AIDS and sexually transmitted infections.

3. Prevention and Treatment Services

a. Voluntary Counseling and Testing Plus

The HIV epidemic in Guyana is in an early-generalized epidemic, with relatively low but increasing HIV prevalence in the wider population and higher concentrations of infection in the most vulnerable populations. Guyana will be served best through targeted voluntary counseling and testing as an entry point into care, support, and treatment for sexually transmitted infections and opportunistic infections, and high-risk behavior reduction (secondary prevention) services for individuals most at risk, and couples at high risk.

Strategically, voluntary counseling and testing services could be coordinated with PMTCT sites to provide male-friendly VCT services for partners of women participating in the PMTCT program, as well as addressing the needs of couples. Counseling and testing services within antenatal clinics or within public facilities perceived by the community as women-oriented are not sufficient. Men are often not comfortable seeking counseling and testing at a facility that provides family planning, antenatal services, and midwifery services.

[41] Centers for Disease Control and Prevention, 2001.

Most at-risk populations require services and information specially segmented to meet their needs. In March 2003, USAID conducted a voluntary counseling and testing countrywide situation analysis that provided information on quality and quantity of current services.[42] Because the analysis did not include target populations, it does not provide sufficient information for a targeted voluntary counseling and testing program.

The situation analysis highlighted four major areas: management, infrastructure, counselors, and HIV testing. Coordination, supervision, and monitoring do not exist on a national scale for voluntary counseling and testing in Guyana. The National AIDS Programme Secretariat provides technical and programmatic leadership, but it does not have a voluntary counseling and testing specialist on staff. CAREC provides intermittent supervision to counselors at public sites. Regional focal persons are needed to coordinate supportive supervision and monitoring of all voluntary counseling and testing services.

The number of voluntary counseling and testing sites is elusive in both the USAID situation analysis as well as in information solicited from the Ministry of Health and the National AIDS Programme Secretariat. Ten administrative regions in Guyana have Ministry of Health or NGO voluntary counseling and testing services. While the private sector undertakes the majority of testing sector, the extent of private sector counseling is unknown.[43]

The USAID situation analysis found that the quality of counseling is commendable at public hospitals in Regions 5 and 6, and at NGO sites in Regions 3 and 10. Paid and unpaid counselors provide services above and beyond their required duties. Confidentiality is high, and one-to-one counseling is always provided. Voluntary counseling and testing is limited because HIV testing is available only in Georgetown. Results can take weeks to return to rural sites. Rapid testing has been recommended. Protocols and infrastructure for rapid testing are in the design process.

Beyond merely testing and counseling, links to care, support, and treatment are an essential part of voluntary counseling and testing.[44] All voluntary counseling and testing sites should provide or make referrals to these services. VCT Plus sites will thus provide antiretroviral therapy for people with AIDS and other care and support on or near the VCT Plus site.

b. Prevention of Mother-to-Child Transmission Plus

The Guyana PMTCT pilot program in eight sites funded by UNICEF and the Government of Guyana is part of the Guyanese National Strategic Plan for HIV/AIDS. This presents an important opportunity for USAID/Guyana to enhance and expand PMTCT services to be supported by the President's Initiative. By the end of January

[42] W. Slater et al., 2003.

[43] Personal communication Dr. Morris Edwards, Acting Director, National AIDS Programme Secretariat, May 9, 2003.

[44] C. Brown, 2003.

2003, 4,669 pregnant women (an estimated 25 percent of all pregnant women) had been offered voluntary counseling and testing as part of their antenatal care, of whom 3,197 (68 percent) accepted the service. The overall HIV seropositive prevalence rate of 3.8 percent varied widely between clinics, from 0.56 percent in Region 6, to 4.8 percent in the clinics in Georgetown. Eighty-two HIV-positive women have since delivered 75 live births (there were 7 infant deaths). Of the HIV-positive mothers who delivered, 48 (59 percent) received nevirapine, as did 56 of the newborns (68 percent). The serostatus of the infants born to seropositive mothers is not known because polymerase chain reaction testing is not available in Guyana.[45]

An evaluation of the PMTCT pilot is currently being analyzed, but early results indicate that nurses who were already stretched are now overworked, with having taken on HIV counseling and the additional paperwork. Confidentiality is a problem, as is stigma associated with receiving nevirapine, and some women have been the brunt of derogatory remarks from staff after delivery and before they leave the hospital.[46] Program managers identified a few key points to consider as services are scaled up. Communication for reporting and logistics is poor. Data analysis is not available to provide program managers with information with which they can plan future activities.[47] Also, PMTCT services highlighted the need for male-friendly testing options in order for couples to receive testing and counseling.

The CDC and USAID/Guyana proposal for supporting PMTCT in Guyana will strengthen and expand the existing pilot program. It will provide nationwide access to voluntary counseling and testing for pregnant women, and increased access to care, support, and treatment for seropositive women and their infants. In a number of pilot sites care, support, and treatment for eligible family members will be provided as part of the PMTCT Plus program. CDC and USAID/Guyana are currently working with the National AIDS Programme Secretariat to develop a national PMTCT expansion plan that will integrate PMTCT with mother and child health services. Although the Ministry of Health has yet to identify funding for the nationwide expansion of the PMTCT program, CDC and USAID support through the President's Initiative will provide financial and technical assistance for training, procurement of equipment and supplies, and infrastructure and laboratory support (including facilities renovation, rapid test kit procurement, interim personnel recruitment, and other HIV-related activities).

c. Antiretroviral Therapy and Opportunistic Infection Treatment

VCT Plus and PMTCT Plus interventions will provide antiretroviral therapy and treatment for opportunistic infections to as many people living with HIV/AIDS as possible. However, HIV-positive people who enter the healthcare system with advanced illness will require treatment as well. A need exists to expand the number of sites able to offer antiretroviral therapy and treatment for opportunistic infections beyond the

[45] M. Edwards et al., 2003.

[46] D. Vitalis, 2003.

[47] Responses to enquiries on PMTCT site visits, Regions 8 and 9, May 8, 2003.

genitourinary medicine clinic (which has 146 patients on antiretroviral therapy) and the New Amsterdam Hospital (which is currently providing treatment for opportunistic infections and psychosocial support to people living with HIV/AIDS). If additional funding becomes available through the President's Emergency Plan for AIDS Relief, USAID/Guyana would be able to expand access to antiretroviral therapy and care and support for people living with HIV/AIDS, possibly by scaling up the genitourinary medicine clinic model at the regional level.

The genitourinary medicine clinic offers syndromic management of sexually transmitted infections, as well as voluntary counseling and testing, and antiretroviral therapy. The genitourinary medicine clinic is an appropriate resource-poor model for regional expansion. Voluntary counseling and testing services are offered to every client who seeks services at the clinic. Free antiretroviral therapy is provided to HIV-positive individuals who have one or more opportunistic infections. For individuals receiving antiretroviral therapy, compliance counseling is provided at each visit. Patients are monitored with liver function tests, though laboratory results take up to two weeks. However, the availability of resources and good logistics are great challenges to the ability of staff at the genitourinary medicine clinic to provide quality service.

Antiretroviral drugs are produced locally by Atlantic Pharmaceuticals. The Ministry of Health does not regulate quality of antiretroviral drug production or private sector patient management. Policy at the national level must change to allow the government to address these issues in the private sector.

d. Human Resources in Health

Although the National AIDS Committee, the National AIDS Programme Secretariat, and the regional AIDS committees are in place to coordinate and advocate for the National HIV/AIDS Programme, they have insufficient staff to meet their roles. The National AIDS Programme Secretariat and the regional AIDS committees both need technical staff, and the regional committees need HIV coordinators and support staff. Current participants on the national and regional bodies serve as honorary members.

The public health sector is only 50 percent to 75 percent staffed, and great inequities exist in the distribution of staff between Region 4, which includes Georgetown, and the hinterland and interior regions. This inequity is particularly evident for physicians.[48] A lack of human resources has been a persistent theme throughout Guyana for many decades. Guyana is the country with by far the largest brain drain in South America, as evidenced by more than 70 percent of Guyanese with a tertiary education having moved to the United States.[49]

Lack of healthcare professionals leads to decreased access to care, lower quality of care, and eventually, decreased demand for services. For example, national program managers

[48] Pan American Health Organization/Ministry of Health, 2002(?).

[49] Carrington and Detragiache, 1999.

are concerned about the quality of HIV counseling that pregnant women receive from nurses who are already overburdened with clinical care and reporting responsibilities, and who are also given the additional responsibility of conducting pretest and posttest counseling. Also, evidence from field visits indicates that because health facilities in the interior are understaffed, some Guyanese cross into Brazil to seek healthcare.

With the hemorrhaging of educated and skilled Guyanese there is a need to consider mechanisms for enticing skilled émigré Guyanese to return to Guyana and incentives to retain trained and skilled citizens. This might be an opportunity for intersectoral collaboration within the Mission's strategy with the economic growth and democracy and governance strategic objectives, because violent crime, and poor pay and conditions undoubtedly contribute to outward migration.

4. Community-Based Care and Support

a. Community-Based Care and Support for People Living with HIV/AIDS Around Prevention and Treatment Services

International experience has shown that providing care and support services for people living with HIV/AIDS and their families is best handled as a community-based intervention. In order to institute an appropriate, comprehensive local response, it is essential to mobilize CBOs and FBOs to reach out to people living with HIV/AIDS, their families, and other vulnerable groups not well served by public health facilities. However, communities must first be helped to address and reduce the stigma and discrimination associated with HIV/AIDS.

The Government of Guyana has identified the needs of people living with HIV/AIDS and other vulnerable groups as a priority in the National Strategic Plan for HIV/AIDS. It calls for people living with HIV/AIDS and their families to be empowered to provide mutually supportive care by the end of the plan, and support groups are to be formed at all treatment sites.

At present, however, few formal mechanisms exist whereby people living with HIV/AIDS, their families, and caregivers can receive care and support to address their nutritional, psychosocial, economic, and legal needs. Only one of the nine NGOs supported by USAID/Guyana—Network of Guyanese Living with HIV/AIDS (G+), located in Georgetown—is made up of people living with HIV/AIDS who define their own needs and advocate for them. Another NGO, the Linden Care Foundation, is attempting to build a network of people living with HIV/AIDS in Region 10. Yet, because of stigma and discrimination in the community, few people living with HIV/AIDS are willing to join.

Communities could provide a variety of care and support services for people living with HIV/AIDS and their families, including home-based care, advocacy for adherence to antiretroviral therapy, and overseeing tuberculosis care (using the DOTS protocol) among HIV-infected persons, which would reduce the burden on an already-overextended public

health system. To provide such services, however, communities, CBOs, and FBOs need to be motivated, trained, and supported both technically and materially.

USAID could use its comparative advantage and experience in working with Guyanese NGOs to support an expanded participation by NGOs, CBOs, and FBOs in the care and support program.

b. Care and Support for Orphans and Vulnerable Children

Children who become orphaned as a result of AIDS often face social, psychological, educational, and economic hardships above and beyond those experienced by other orphans and vulnerable children because of the stigma attached to AIDS. In addition, orphans may lack adult supervision and economic resources and may themselves engage in risky sexual activities that increase their vulnerability to infection with HIV. The social and economic support services now available to people living with HIV/AIDS and their families in Guyana are limited, with just the Linden Care Foundation known to be providing for the needs of orphans and vulnerable children. Relatives are encouraged to take in children orphaned by AIDS, however, with a burgeoning epidemic the burden on extended families will be substantial. Extended families caring for orphans and orphans with no identified means of support will need guidance, and social and economic assistance, to ensure that orphans and vulnerable children remain healthy and continue in school.

Little is known about the number of orphans and vulnerable children resulting from the AIDS epidemic in Guyana. UNAIDS estimates that Guyana has 4,200 AIDS orphans.[50] Anecdotal evidence suggests that a small proportion of these are cared for in homes for children operated largely by religious charities. Some have been taken in by extended families, although the fear that these children may be HIV-positive often means that family members or potential foster parents shun them. Some have found their way into a few of the country's public hospitals where they have been "adopted" by the staff. A few, like those in Linden, are receiving limited NGO support, especially for education. Most orphans, however, apparently find themselves cast out and living with other homeless children on the streets of Georgetown and other cities and towns throughout the country.[51]

When and if more resources become available through the Presidential Emergency Plan for AIDS Relief, renewed efforts to address the needs of orphans and vulnerable children will be required. Given that communities are potentially best positioned to care for their own orphans and vulnerable children, mobilizing CBOs and FBOs by way of national NGOs will be the way to start.

[50] UNAIDS, 2002.

[51] Informal NGO consultation, May 10, 2003.

III. USAID/GUYANA STRATEGY

A. Rationale for the Strategy

With a relatively low HIV prevalence and a generalized epidemic, Guyana requires a targeted intervention approach as well as a generalized effort to reduce stigma in order to achieve the greatest impact on the epidemic. Mapping high-risk behaviors and surveying the most-at-risk populations will provide data for behavior change interventions to reduce risky behaviors, and for diagnosis, care, and support programs. USAID/Guyana works to develop the capacity of youth-focused NGOs individually and as members of a network of NGOs. These NGOs still have limited ability to reach most the vulnerable populations while focusing broadly on youth.

Guyana's healthcare structure is characterized by weaknesses in management information systems, procurement logistics, and supplies of essential drugs and commodities. Imbalances exist in staffing between Georgetown and the coastal communities, and the interior of the country. Importantly, a large proportion of health sector posts are unfilled. The public sector reform process supported by the Inter-American Development Bank has led to a reduction in public staffing via attrition, and has restricted the creation of new posts—including those required in efforts to prevent transmission of HIV from mother to child and other responses to the HIV epidemic—to posts for which there is a sustainability plan.

Many facilities are inefficient because they are underused. While mother and child health facility-based services are adequate, there is no community-based infrastructure or outreach to vulnerable populations not well served by static health facilities. The result is poor access to healthcare by highly vulnerable populations such as mobile populations of miners and loggers, commercial sex workers, and men who have sex with men. Recently, a few NGOs have begun to respond, but this needs considerable continued strengthening. Few communities, CBOs, and FBOs have been mobilized to respond to the HIV epidemic. Voices for the needs and rights of people living with HIV/AIDS are only just being raised, and stigma is a major problem.

In Guyana, 80 percent of pregnant women use Ministry of Health antenatal care services, and USAID/Guyana has identified the government's mother and child health program and its 15-month PMTCT eight-site pilot as an opportunity to expand PMTCT services. Without USAID support, PMTCT services are likely to remain limited. Even with strong Ministry of Health commitment, the existing healthcare system and the limited NGO capacity can offer care, support, and treatment only on a limited basis. The USAID/Guyana program will focus on reducing risky behaviors by the most vulnerable populations and seropositive people who enter the healthcare system through targeted prevention and treatment services such as VCT and PMTCT, funded through the President's International Mother and child HIV Prevention Initiative. With additional funding, it will be possible to expand treatment, care and support services to people living with HIV/AIDS and their families by offering additional technical support and building

the capacity of the decentralized health system, and of NGOs and their partner CBOs and FBOs.

The Universal Framework of Objectives[52] is a tool for ensuring a comprehensive and multisectoral response to HIV/AIDS. The Guyana strategic plan is unable to cover all aspects of the Universal Framework for Objectives because funding, USAID/Guyana management capacity, absorptive capacity by the Government of Guyana and local NGOs, and USAID comparative advantage, along with other donor interests, do not permit such a holistic approach. Recommendations for the Guyana strategic plan were developed from a thorough analysis of the wider possibilities, needs, resources, and USAID manageable interests.

When addressing prevention in a low-prevalence generalized epidemic, reduction of HIV transmission is of paramount importance to limit the overall extent of the epidemic and its consequences. In the Guyanese context this requires sexual risk behavior reduction, especially by those in most-at-risk populations. Reducing the prevalence and duration of sexually transmitted infections requires both a reduction in sexual risk behaviors, and greater access to treatment services for sexually transmitted infections. In Guyana, this can occur by scaling up the genitourinary medicine clinic model on a regional basis.

Injecting drug use risk behavior is not believed to be a significant factor in the epidemic in Guyana. Blood donors in Guyana are tested for HIV using the enzyme-linked immunosorbent assay test, the ELISA test—the only technology available—although this testing can occur after the blood has been transfused into the recipient, especially when urgent and emergency transfusions occur from blood donated by relatives. For blood donors in general, blood donation drives are self-selected as low risk because it is widely known that donors are tested for HIV, and people do not want to risk others finding out that they are HIV-positive through having their blood donation refused. Nevertheless, blood transfusions are rare; they are reserved for immediate, life threatening and other urgent situations, and are unlikely to be a major influence on the epidemic in Guyana. With the exception of mothers who seek antenatal care and infants receiving for immunizations, Guyanese do not have wide exposure to public sector healthcare services. Therefore, strategically, it is better to concentrate USAID resources on reducing sexual risk behavior rather than addressing a relatively small potential health service contribution to the epidemic. Training staff who provide mother and child health services in the PMTCT program should include reducing the risk of health service transmission of HIV and universal precautions because this will incur only marginal costs to the PMTCT program. Should further funding become available, antiretroviral therapy will be available to seropositive persons diagnosed with one or more opportunistic infection.

Ensuring community ownership is an important area for USAID/Guyana to strengthen . The capacity of the network of HIV/AIDS NGOs should be built to work with CBOs, FBOs, schools, and other community organizations. The participation of "peers" identified by the most-at-risk population groups to represent their communities in

[52] S. Hunter, 1997.

program planning, and to raise societal and community awareness must be assured. Community participation involving the most-at-risk populations and wider communities to address stigma and assure community-based care and support services for people living with HIV/AIDS and orphans and other vulnerable children affected by AIDS should be met within the Guyana strategic plan.

Minimizing the loss of human resource through workforce planning, training, and workplace initiatives is a component of the Guyana National Strategic Plan for HIV/AIDS. However, strategically, USAID/Guyana can give only limited support to such a strategy by advocating for multisector responses, because efforts by USAID/Guyana must focus on transmission education, voluntary counseling and testing, prevention of mother-to-child transmission, and, should further funding become available, antiretroviral therapy.

Stigma and discrimination reduction and protection of human rights will, in part, be addressed as a crosscutting issue in the USAID/Guyana strategic plan. Because policy and leadership at the highest level are needed for stigma reduction efforts, this should be a feature of advocacy work in a comprehensive response to HIV/AIDS. Special effort must be made to ensure that increasing risk-reduction practices by the most-at-risk populations does not stigmatize vulnerable people. Community dialogue and action by NGOs CBOs, FBOs, and others must be used to reduce stigma associated with HIV/AIDS, people living with HIV/AIDS, and condom use. Making prevention and treatment services available must be done in a way that respects the confidence and rights of those who use services and does not stigmatize service users. Pregnant women who are diagnosed as seropositive must have access to voluntary counseling and testing for their regular sexual partner so that the woman is not stigmatized as being seropositive without her partner having the opportunity to seek counseling and testing. Community-based care and support services must go hand-in-hand with stigma reduction to ensure greater use of these services by people living with HIV/AIDS, orphans and vulnerable children, and other children affected by AIDS.

B. Most-At-Risk Populations

Although hard data are lacking, social scientists and public health experts agree that a few most-at-risk populations contribute disproportionately to the growth of Guyana's epidemic. Further evidence from surveys of behavioral surveillance (by USAID) and serological surveillance (by CDC), as well as high transmission area mapping (by USAID and CDC) must be utilized to strategically design and implement programs, as well as to estimate the size of the most-at-risk populations, which then becomes the denominator for monitoring performance in providing services and the effects of interventions. Based on international epidemiological evidence, the following are likely the most-at-risk populations for HIV transmission:

Male and female commercial sex workers: Commercial sex workers in Georgetown are reported to have HIV prevalence rates of up to 45 percent.[53] The Minister of Health[54] reported that Guyana has both male and female sex workers, and some may accept additional payment if a client requests they not use a condom. In addition, female commercial sex workers with Guyanese clients reportedly have significantly higher prevalence rates of HIV infection (36 percent) than those whose clients are exclusively foreign (6 percent prevalence).[55] These local clients are an important bridge of transmission to the general population. Transvestite commercial sex workers also practice risky behaviors. In addition, some young men frequent areas seeking transactional sex with other men. Some self-identify as men who have sex with men, while others may identify as being heterosexual, but are willing to have transactional sex with men when they are in need of money. Anecdotal evidence suggests that transactional sex for shelter, food, and protection is also common in other regions outside of Georgetown.

Itinerant workers or others separated from their wives and regular partners (miners, loggers, farmers): Men are often drawn to jobs that require temporary displacement from their homes for extended periods of time. Despite the physical hardship, wages are often two to three times higher than in urban cities, and many men leave their families for a few years to provide a better standard of living for their families. In a recent study conducted in an Amazonian mining camp, 216 Guyanese men aged 18–35 were tested for HIV, and 6.5 percent tested positive.[56] Results of this small study reveal the enormous potential for further transmission of HIV in Guyana due to migration of city dwellers seeking employment opportunities. Commercial sex workers often follow such camps and set up "apartments" in small villages nearby, which further exacerbates the situation.

Minibus drivers and conductors: Numerous minibuses are licensed and zoned by the Ministry of Communication and Works. Drivers use 12–15 seat minibuses to provide commuter services on public roadways.[57] Anecdotal evidence indicates that they are considered "cool" because they have money, and have several girlfriends, particularly schoolgirls or students. Girls can offer or be persuaded to have sex with a minibus driver or conductor in exchange for free travel. Minibus drivers and conductors are reported to have several liaisons of this nature and often engage in unprotected sex. Planned improvements in road transportation between Guyana and Brazil will further increase their mobility. Minibus drivers currently traverse a road that links all the coastal areas, but they have limited access to hinterland regions, depending on the seasonal quality of roads. The proposed Guyana-to-Brazil road is expected to increase mobility across the border and spread the epidemic through this key vulnerable population.

[53] Centers for Disease Control and Prevention, 2001.

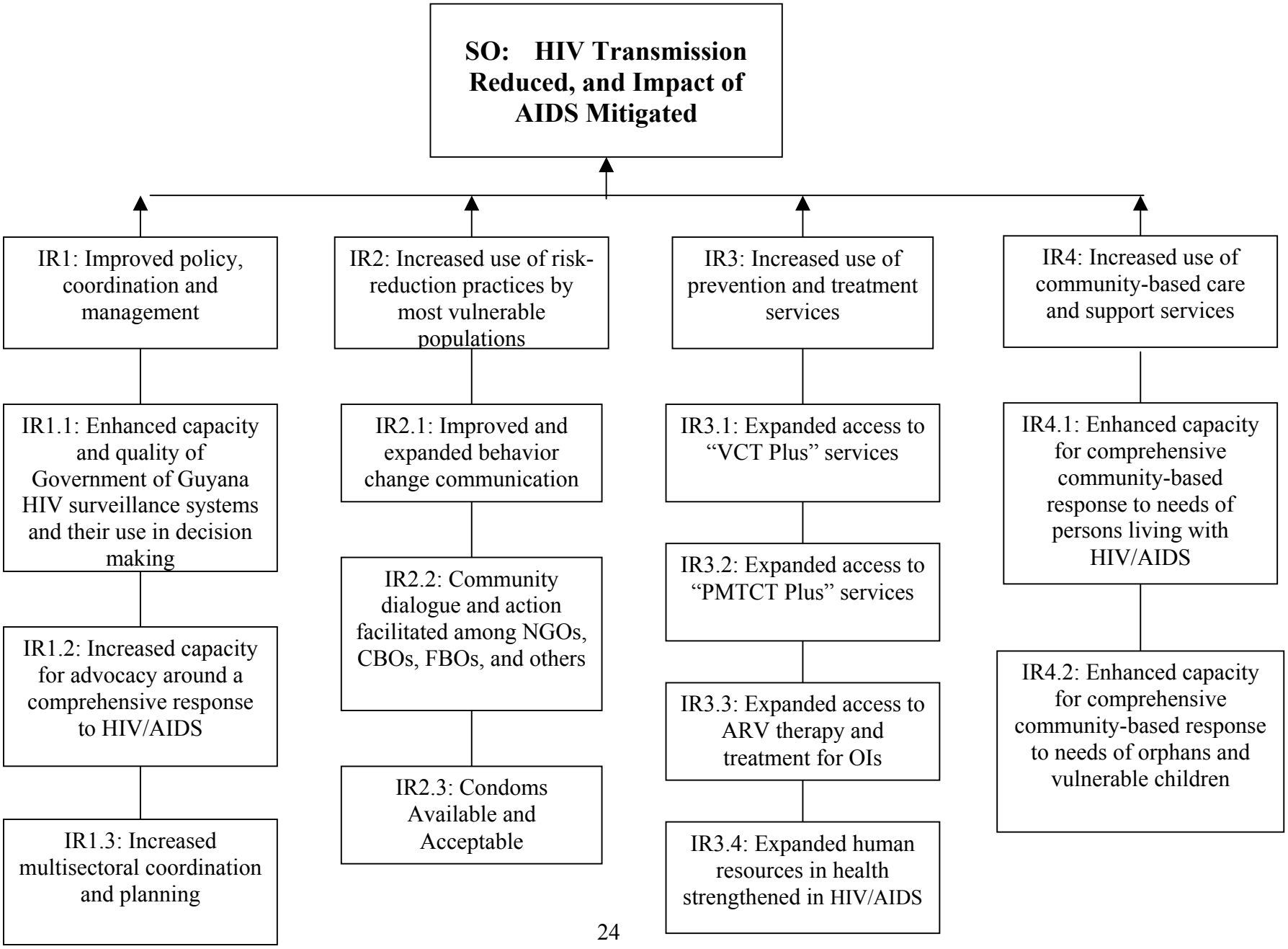
[54] Interview with Dr. Leslie Ramsammy, Guyana's Minister of Health.

[55] C. Allen, 2000.

[56] C.J. Palmer et al., 2002.

[57] Family Health International, Undated.

The USAID/Guyana SO3 Results Framework for 2004–2008



C. Development of the Strategic Objective and Results Framework

1. The Strategic Objective

USAID/Guyana is unusual in having an HIV/AIDS strategic objective (SO) while not having a related health result for 2004–2008. The HIV/AIDS SO3 could capitalize on opportunities afforded from SO1 for economic growth and SO2 for democracy and governance. Public sector remuneration packages and the wider Guyanese political environment, along with personal security, directly influence both the retention of skilled personnel and the ability to entice qualified émigré Guyanese to return to Guyana.

These are critical issues for the scale up of the response to HIV/AIDS, and thus there are clear points of synergy with the economic growth and the democracy and governance sectors of the Mission strategic plan. The health of the workforce influences the state of the Guyanese economy and the ability of families, communities, and the government to mitigate the effects of the epidemic, thus opening additional areas whereby the economic growth and democracy and governance sectors of the Mission program can be incorporated into achieving an HIV/AIDS SO3.

In general, the aim of USAID/Guyana is to support and strengthen the implementation of the Guyanese National Strategic Plan for HIV/AIDS. This plan is comprehensive and well thought out within the Guyana context, but it will be fully and effectively implemented only with donor technical support and funding. Nevertheless, there is the need to focus USAID support to implementing the national strategic plan to areas of U.S. competitive advantage where maximum impact can be achieved within the life of the USAID/Guyana strategic plan for 2004–2008.

The epidemic in Guyana follows a generalized pattern with relatively low prevalence and likely concentrations of higher rates of infection in highly vulnerable populations. With limited funds available for prevention, this strategic plan must focus on reducing transmission in populations that have highest transmission of HIV infection, while stabilizing transmission in the wider population, if it is to have maximum impact on reducing transmission over the 2004–2008 period.

Funding from the President's International Mother and Child HIV Prevention Initiative will be directed to expanding voluntary counseling and testing services, and prevention of mother-to-child transmission services throughout Guyana. Should further funding become available, treatment, care and support activities will be added. For maximum impact, these activities should be clustered with both the enhanced Ministry of Health services and systems for voluntary counseling and testing, and prevention of mother-to-child transmission, and stronger NGOs, CBOs, FBOs, and peer counselors who promote behavior change, demand for services, and a reduction in the stigma associated with HIV/AIDS.

These considerations lead to the formulation of the SO as: SO3: **HIV transmission reduced and impact of AIDS mitigated.** USAID/Guyana will monitor progress in achieving this SO by reporting on

- HIV seroprevalence among commercial sex workers, and
- Number of HIV-infected women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission.

2. Intermediate Result 1

Analysis of the HIV/AIDS policy environment, coordination of services, and management of the problems and opportunities in Guyana indicates that deficiencies exist. These deficiencies include weaknesses in basic data collection and use to facilitate both program intervention design and monitoring progress toward achieving results, through lack of coordinated and collaborative multisector responses—both between government ministries and between the public and the private sectors. Those advocating for an effective response to HIV/AIDS, and the rights and needs of people living with HIV/AIDS, lack capacity and authority to do so. These are weaknesses that limit Guyana from effectively implementing its national strategic plan. USAID can respond to Guyana's HIV/AIDS needs by harnessing its strength in advocacy, coordination, and second-generation surveillance experience worldwide, as well as the strengths of CDC, in the first intermediate result designed to achieve **IR1: Improved policy, coordination, and management**.

USAID/Guyana will monitor and report on the achievement of this intermediate result through construction of the AIDS Program Effort Index.[58]

Interventions to Achieve IR1

First and foremost, efficient and effective implementation of the Guyanese National Strategic Plan for HIV/AIDS requires reliable data to plan and operate services and to monitor progress toward achieving the plan's targets. Reliance on passive reporting of AIDS cases and deaths from AIDS is not adequate. An effective second-generation surveillance system is mandatory, with Ministry of Health capacity being enhanced to analyze and use the data for the purpose of focusing resources and services in the regions, rather than a simple aggregation of data and forwarding them to the national level.

Similarly, USAID/Guyana needs to address deficiencies in basic data collection and use to facilitate its program planning, implementation of activities, and monitoring progress toward achieving the results. Thus, one intervention to achieve IR1 will result in **Enhanced capacity and quality of Government of Guyana HIV surveillance systems and their use in decision-making.**

[58] Policy Project, 2000.

Illustrative Activities:

1. USAID/Guyana will conduct further in-depth formative/ethnographic mapping to identify access points to the most-at-risk populations. Great care must be taken to involve all stakeholders in the preliminary selection of these populations, and identify appropriate gatekeepers and "peers," who can provide input when mapping hotspot, high-transmission areas. This preliminary mapping is critical to indicate the extent of sexual networking between the most at-risk populations and the general population, and highlight high-transmission areas that should serve as focal points.

2. Estimating the size of target populations will be undertaken with technical assistance from an international NGO.

3. Supporting the development of behavior surveillance surveys. This would be part of a second-generation surveillance system with CDC supporting serosurveillance to accurately guide the design of appropriate prevention and treatment programs and to monitor whether these efforts are successful.

4. Surveillance data analysis. USAID (through behavioral surveillance surveys) and CDC (through serological surveillance) data will be analyzed in collaboration with a local institution (i.e., CESRA; University of Guyana), whose capacity will be strengthened.

5. Building capacity to use data for program design nationally and regionally. Once the data are analyzed, technical assistance to disseminate and use the data in a meaningful way that guides program design, implementation, and evaluation will also be critical to relevant stakeholders and "peers." Involving representatives of the most-at-risk populations, stakeholders, and gatekeepers early in the identification, mapping, data collection, and analysis will ensure that the data generated are credible and put to use.

Secondly, the lack of clear acknowledgement of responsibility and leadership at the highest levels must be addressed. Those advocating for an effective response to HIV/AIDS, and for the rights and needs of people living with HIV/AIDS, lack capacity and authority. USAID/Guyana can draw on USAID advocacy experience globally for the second intervention required achieving IR1 with the result of: **Increased capacity for advocacy around a comprehensive response to HIV/AIDS**.

Illustrative Activities:

1. Advocacy. USAID/Guyana will provide technical assistance to promote free and open discussion of HIV/AIDS among Guyana's senior-most political and religious leaders and other influential people such as media and sports stars, garnering support for anti-stigma efforts and action from political wives as well as politicians. This might be undertaken in collaboration with activities under the democracy and governance SO2, toward a transparent intermediate result.

2. Facilitating a multisector response. Activities are also needed at the highest level of government to facilitate a multisector response, and to ensure collaboration and

cooperation between government ministries. The Government of Guyana must ensure that the multisector concept is devolved to the regional democratic councils and that the regional AIDS committees are constituted with representation from government ministries, as well as from civil society and the private sector.

3. Building the capacity of NGOs, CBOs, and FBOs to lobby and advocate. This might be achieved by contracting an international NGO to build the capacity of local NGOs—including organizational development—to mobilize and strengthen NGOs, CBOs, FBOs, and their peer counselors who work with the most-at-risk populations, to lobby and advocate for the legal rights of people living with HIV/AIDS, and to promote greater access to treatment and care on their behalf.

Third, capacity must be built at national and regional levels for planning coordinated and collaborative multisector responses—both between government ministries and between the public and the private sectors. One level of multisector planning is within the USAID/Guyana portfolio, the second level is between units within ministries, between Government of Guyana ministries, and with the nongovernment sector nationally; and the third level is intersectoral planning between government ministries and with the NGO sector regionally.

Thus the third intervention to achieve IR1 must result in: **Multisectoral coordination and planning increased**.

Illustrative Activities:

1. Integration with the economic growth SO1. This might include collaboration in microenterprise programs to assist people living with HIV/AIDS and their families to maintain economic self-sufficiency, or expansion of employer-based programs to benefit people living with HIV/AIDS.

4. Integration with the democracy and governance SO2. This might provide training for national, regional, and local political leaders on individual risk-awareness and reduction, the social and economic effects of HIV/AIDS, and on stigma and discrimination reduction. Collaboration with the Ministry of Labor might introduce, strengthen, and enforce HIV/AIDS nondiscrimination policies in the workplace.

5. Increasing capacity for multisector planning. Technical assistance will be needed to facilitate multisector planning at the national level and to increase the capacity of the National AIDS Programme Secretariat to facilitate multisector planning at the regional level. This might be achieved by contracting a short-term consultant to serve as counterpart to the National AIDS Programme Secretariat director to plan and hold multisector planning meetings and then facilitate regional meetings, or through a global project such as the Policy Project.

3. Intermediate Result 2

Guyana has a small population and indications are that, although the epidemic has become generalized, prevalence of infection in the wider population is still relatively low. However people who transmit HIV at higher rates because of risky behaviors, and persons with whom they practice risky behaviors, are likely to have far higher prevalence rates of HIV. Thus the most effective means of achieving the reduced transmission component of SO3, and containing the spread of HIV is by: **IR2: Increased use of risk reduction practices by most vulnerable populations.**

USAID/Guyana will monitor and report on the following indicators:

- Median age at first sex among young men and women;
- Condom use with last client among commercial sex workers; and
- Number of condoms sold or distributed.

Interventions to Achieve IR2

This intermediate result requires NGOs to identify and convince at-risk populations to change their risky sexual behaviors. Mass media social marketing of healthy sexual behaviors, and social marketing sales agents establishing condom outlets in non-traditional sites frequented by the most vulnerable populations can provide an environment conducive to risk reduction. Interpersonal communication and empowerment approaches to behavior change must also be a major program component to achieve reduction of risky sexual behaviors in the most vulnerable populations. Thus an important intervention to achieving IR2 will have the result of: **Behavior change interventions improved and expanded**

Illustrative Activities:

1. Technical assistance to NGOs in behavior change interventions that employ empowerment approaches with the most-at-risk populations. National-level workshops might be facilitated to mobilize local NGOs to focus their behavior change interventions on the most-at-risk populations. This would provide information from the second-generation surveillance system to help them (a) identify AIDS hotspots (localities where NGO activities should be focused), and (b) understand the risky behaviors. Further, the workshop would provide skills training and materials needed for empowerment approaches, including the selection, training and support of peer counselors.

2. Identifying, training, and supervising peer counselors in the field from high-prevalence populations. NGO capacity will be made stronger so that NGOs can employ an outreach worker who will work directly with local at-risk populations. Outreach workers are most effective when they are identified as a member of the local most-at-risk populations and after they receive knowledge and skill-based training to become change agents. Outreach worker can then work with the most-at-risk populations to identify members of their community who are acceptable and willing to receive training to serve as peer counselors. Peer counselors have

credibility, motivation, and with their new behavioral change intervention skills, the ability to communicate effectively with their peers. The NGO peer counselors identify groups of their peers, provide factual information on risk and safe practices, guide peers to condom outlets, and encourage peers to take advantage of voluntary counseling and testing services, treatment for sexually transmitted infections, and other health services. Implementation requires the NGO outreach worker to provide supportive supervision of the peer counselors, and also for the NGOs to have their own meeting places where people can ask questions and seek advice from the outreach worker, and receive services.

3. Serial focus groups with the most-at-risk populations to address sexuality and risk reduction. This might be along the lines of a modified Stepping Stones[59] approach to identify and address issues in communities that encourage risky behavior. The Stepping Stones approach, which was found effective in Uganda, provides skills for focus groups to communicate on subjects such as sexuality, which are often taboo between different generations and genders.

4. Development of behavior change communication messages. Implementation of the USAID program will require communication specialists to work with NGOs and their outreach workers to agree on the important behavior change communication messages for high-prevalence populations. Ideally, the peer counselors or other people who represent those in the most-at-risk population groups should participate. Different messages are needed to reach male commercial sex workers and their clients—men who have sex with men, and men who have sex with transvestites—as well as female commercial sex workers—uptown, brothel, street based—and their clients. Great care must be taken to promote the use of voluntary counseling and testing services for HIV and sexually transmitted infections by commercial sex workers, without fear of stigma, discrimination, or further marginalization.

Because it is important that community behavior norms support a reduction in risky behaviors, communities need to be mobilized around risk reduction for HIV. It is important that organizations and groups that have influence in the community such as CBOs, FBOs, school clubs, and parent-teacher associations undertake these mobilization efforts. These groups are not well connected to government agencies, and thus another intervention to achieving IR2 needs to result in: **Community dialogue and action facilitated among NGOs, CBOs, FBOs, and others.**

Illustrative Activities:

1. Give local NGOs the capacity to mobilize CBOs, FBOs, and others. NGO capacity—including organizational capacity and staffing—might be strengthened to allow community activities in localities to be identified as a priority for risk-reduction activities. This will require particular attention to working with all religions as well as additional efforts, which have little reach into Muslim populations and virtually none into Hindu populations of the Indo-Guyanese community. NGOs working with the

[59] A. Welford, 1995.

Indo-Guyanese community will need to employ Indo-Guyanese staff members who understand cultural mores and traditions.

2. Create a map NGO staffing resources to meet the local response. CBOs, FBOs, and other groups that are active and influential in their localities are an important resource for meeting the local response to HIV in areas of high transmission. It is important that all potential groups be identified and encouraged to participate to recognize personal risk, stigma reduction, and risk reduction, and to provide care and support for people living with HIV/AIDS, orphans, vulnerable children, and other children affected by AIDS.

3. Facilitate local programs of talks, discussions, and action planning with CBOs, FBOs, and other local groups. NGOs could be supported to develop program implementation plans that include a comprehensive, series of meetings with CBOs, FBOs, and other groups in their locality. At first NGOs could sensitize the other groups to HIV, individual risk, stigma reduction and risk reduction issues, then discuss the role of CBOs, FBOs, and others. Finally, the NGOs could develop action plans for activities that will support the involvement of CBOs, FBOs, and other local groups to support the program.

A major risk-reduction strategy for many of the most-at-risk populations, including commercial sex workers and men who have sex with men, is the promotion of 100 percent condom use. This strategy is also important for all persons who are sexually active outside monogamous relationships and for those who practice anal intercourse. Because Guyanese youth may practice anal intercourse without recognizing it as risky sexual behavior, an important benefit from a well-designed program that promotes 100 percent condom use will be to include all sexually active youth in the segmentation of the program. The intervention contributing to achieving IR2 will result in: **Condoms available and acceptable.**

Illustrative Activities:

1. A brand-specific social marketing campaign for condoms. The campaign would be positioned to appeal to the most-at-risk populations and to address all sexually active men and women while segmenting the messages to address the needs of those who practice anal intercourse. Supplies of brand condoms would be made widely available and affordable in localities frequented by the most-at-risk populations, including rum shops, convenience stores, bus stands, and brothels.

2. Community-based distribution of condoms. This might be undertaken in conjunction with peer counselor activities so that peer counselors have supplies of condoms to demonstrate their effective use to peers, and to encourage their peers to begin the habit of using condoms (i.e., free starter packs) with follow-on supplies available at cost from other vendors.

4. Intermediate Result 3

Because Guyana has been selected as a beneficiary of the President's International Mother and Child HIV Prevention Initiative and the President's Plan for Emergency AIDS Relief, a third intermediate result contributing to SO3 must reflect prevention of mother-to-child transmission interventions and other interventions that identify and provide treatment for people living with HIV/AIDS, with the result of: **IR3: Increased use of prevention and treatment services.**

USAID/Guyana will monitor and report on the following indicators:

- Number of individuals accepting counseling and testing;
- Number of pregnant women accepting counseling and testing;
- Number of HIV-infected individuals receiving treatment or prophylaxis for opportunistic infections; and
- Number of USAID-supported health facilities offering prevention of mother-to-child transmission services.

Interventions to Achieve IR3

Voluntary counseling and testing is the entry point both to prevention through risk-reduction practices in seropositive persons and to care and treatment by the formal health services and in the community for people living with HIV/AIDS. Therefore, an important intervention toward achieving IR3 is expanding access to VCT Plus services, giving the result: **Expanded access to VCT Plus services.**

In Guyana, voluntary counseling and testing is available through the genitourinary medicine clinic in Georgetown, and through pilot voluntary counseling and testing sites, including three VCT for Youth sites supported by USAID/Guyana, and other sites in Regions 4 and 6 supported by CAREC/GTZ. Private laboratories are believed to undertake a significant volume of testing. A variety of voluntary counseling and testing models could be used to effectively expand these services.

Illustrative Activities:

1. Provide male-friendly voluntary counseling and testing sites for partners of women who participate in the prevention of mother-to-child transmission programs. This is an important activity to avoid stigmatizing women as the cause of HIV in communities where antenatal care PMTCT services do not serve partners of pregnant women and other couples at risk for HIV infection. Freestanding VCT sites will be positioned within the same locality as PMTCT services in order to provide men and couples with additional counseling and testing options.

2. Establish voluntary counseling and testing procurement and logistics systems. Such systems are required to reliably supply rapid test kits and other commodities needed for current and future voluntary counseling and testing sites. Training and other staff support will be a priority. CDC will address laboratory infrastructure and quality.

3. Integrate voluntary counseling and testing services with other programs that support the most-at-risk populations. Depending on the results of the mapping and

surveillance surveys, some NGOs, especially those working with specific at-risk populations, may be trained to provide counseling and testing. At a minimum, the NGO and outreach peer counselors will facilitate community readiness for voluntary counseling and testing and provide referrals to voluntary counseling and testing services.

4. Expand the genitourinary medicine clinic model to four regions. Syndromic management of sexually transmitted infections is an appropriate model of care for regional services in Guyana. The Ministry of Health is considering concentrating its regional AIDS committees and regional management of health services in four regions, and capacity could be built to support genitourinary medicine clinics in each of these four regions. Voluntary counseling and testing should be an integral part of the regional genitourinary medicine clinic services, with antiretroviral therapy available to those who are seropositive and have signs of two or more opportunistic infections.

5. Integrate and link voluntary counseling and testing services with treatment, care, and support programs. All facilities that provide voluntary counseling and testing must provide referrals to services for treatment of opportunistic infections and co-infection with TB if they do not themselves provide these services. Similarly, linkages to community groups that provide psychosocial support are essential if the voluntary counseling and testing service itself does not facilitate post-test groups or clubs. Should further resources for antiretroviral therapy become available, voluntary counseling and testing services must provide antiretroviral therapy or refer clients to other sites that provide antiretroviral therapy.

The President's International Mother and Child HIV Prevention Initiative supports PMTCT Plus. It comprises a three-pronged approach of preventing infection in infants, and a fourth prong of providing long-term care and support to families, especially mothers and young children. The President's initiative will provide full antiretroviral therapy to women and their spouses, based on their health status and the capacity of the healthcare system. The three prongs concerned with prevention are:

- Prevention of HIV infection in young women;
- Prevention of unwanted pregnancies in HIV-positive women; and
- Provision of antiretroviral prophylaxis to all HIV-positive pregnant women to reduce mother-to-child transmission, along with infant feeding counseling.

Because Guyana has poor laboratory infrastructure, the antiretroviral prophylaxis is nevirapine, given as a single dose to the mother at the onset of labor and a single dose to the infant at birth. Long-term care and support for the family should include treatment for sexually transmitted infections, opportunistic infections, and co-infection with TB. If further funding becomes available, antiretroviral therapy for the infant, mother, father, and other eligible members of the family will be provided. In Guyana, antiretroviral therapy commences in the presence of one or more opportunistic infections. Therefore, a second important intervention to achieving IR3 will result in: **Expanded access to PMTCT Plus services.**

Current PMTCT services located within antenatal care settings provide pregnant women with counseling and testing, and family planning. The USAID/Guyana proposal, incorporated within this strategic plan, includes a phased approach to expand the pilot sites and close collaboration with CDC.

Illustrative activities:

1. First phase of expansion. The eight pilot sites will continue, and 12–24 new sites will incorporate prevention of mother-to-child transmission services into the Ministry of Health mother and child health program. Treatment for advanced HIV infection, indicated by the presence of two opportunistic infections, will include antiretroviral therapy, and will be offered at three sites in the first 18 months. All facilities will ensure referral to clinical services that are unavailable on site.

2. Second phase. Expanded coverage will be completed to 32 sites that will be maintained with support from USAID/Guyana and CDC. Care and treatment for sexually transmitted infections, opportunistic infections, and co-infection with TB will be more widely available for mothers, their partners, and their families through PMTCT sites by 2008. Those sites that do not offer complete care and treatment for sexually transmitted infections, opportunistic infections, and co-infection with TB, will ensure that appropriate referrals are made. Should further funding become available, antiretroviral therapy will be made available for treatment for HIV infection in mothers, partners, and other family members who have two opportunistic infections, at all sites by 2008. All facilities will ensure that referrals are made to clinical services that are unavailable on site.

3. Third phase. Outreach to all pregnant women, including those who do not seek antenatal care will be addressed. The Government of Guyana and USAID are committed to ensuring universal access to antenatal care, safe delivery, and HIV services. Behavior change interventions that create demand for both mother-to-child transmission prevention services and antenatal care will be carried out throughout the program.

4. Assistance at the national level, including policy development, monitoring and evaluation, operations research, and data analysis and reporting.

5. Enhanced logistics, and communications. Technical assistance to improve the system will also be provided by USAID/Guyana. Equipment and supplies will be purchased for the PMTCT program. Drugs and other commodities will be stored and distributed through the Ministry of Health. A communication system is integral to logistics as well as reporting. The routine health information system will be enhanced and forms revised to include PMTCT services. The regional focal person will coordinate regional reporting. Data will be analyzed and used for decision-making purposes at the regional level.

For patients with AIDS, the current treatment program, which is available only through the genitourinary medicine clinic in Georgetown, includes diagnosis—based on HIV

testing and the presence of two or more opportunistic infections—counseling; antiretroviral therapy; and treatment for sexually transmitted infections, opportunistic infections, and co-infection with TB.

VCT Plus and PMTCT Plus interventions will provide antiretroviral therapy and treatment for opportunistic infections treatment to wider populations of people living with HIV/AIDS. However, HIV-positive people lost to follow-up or migration, and people who enter the healthcare system with advanced illness require treatment as well. Should further funding become available, expansion of these treatment programs through the regional health services beyond Georgetown will be a focus of the USAID/Guyana program with the result supporting IR3: **Expanded access to antiretroviral therapy and treatment for opportunistic infections.**

Illustrative Activities:

1. Train regional genitourinary medicine clinic staff members. USAID/Guyana could provide technical assistance to build the capacity of the Genitourinary Medicine Clinic in Georgetown to allow staff there to provide training and on-the-job supervision for regional genitourinary medicine clinic staff. This training might also be offered on a fee-for-training basis to doctors in the private sector. The National AIDS Programme Secretariat has indicated its willingness to allow private sector doctors to access low cost antiretroviral drugs if the doctors receive training in their ethical use. The Ministry of Health would have to negotiate with the Guyana Medical Council that the training be accredited and eligible for continuing medical education credits. Each doctor registered with the Guyana Medical Council must earn six continuing medical education credits annually to be eligible for annual re-registration.

2. Address quality assurance and guidelines. Current USAID funding does not allow for treatment outside of VCT Plus and PMTCT Plus. Other international partners are expected to address guidelines, protocols, and quality assurance for laboratories, antiretroviral drug production, and antiretroviral therapy management. If additional USAID funds for an antiretroviral therapy program become available, an initial quality assessment will be required before services can be expanded. USAID or other partners with appropriate expertise may complete the assessment.

Although the Guyana public sector has a critical shortage of skilled personnel, the private sector does have personnel. The Ministry of Health must address retaining skilled personnel and enticing skilled émigré Guyanese to return to Guyana to staff the response to HIV/AIDS. This is an intersectoral issue to be addressed within the Mission strategy, as well as a health sector issue through which USAID/Guyana can build capacity within the Ministry of Health. However, there remains a need for an intervention to support IR3 that will result in: **Human resources in health expanded and strengthened in HIV/AIDS.**

Illustrative Activities:

1. Technical assistance to the National AIDS Programme Secretariat for training in voluntary counseling and testing and epidemiology, and public health approaches for

staff assigned to vacant Secretariat posts.

2. Technical assistance for training for regional AIDS committee staff. A salaried, technical person needs to be assigned as a focal person to each regional AIDS committee to provide supervision, coordination, and reporting. USAID/Guyana could provide technical assistance for training and supervision for the regional focal person. The focal person's main responsibilities would be to oversee antiretroviral therapy for eligible persons identified through the VCT Plus and PMTCT Plus programs; supervise counselors for VCT/PMTCT Plus programs; oversee logistics for VCT Plus and PMTCT Plus; and coordinate routine health information systems. After 18 months, a monitoring and evaluation specialist will support each focal person. She or he will be responsible for the regional health information system and for surveillance, including data analysis and disseminating data to facilities and the central office.

3. Salaried counselors could reduce the burden of counseling on nursing staff. Counselor responsibilities would include pretest and post-test counseling as well as providing guidance on risk-reduction behaviors, providing family planning information and making referrals, and offering support for people living with HIV/AIDS such as facilitating post-test clubs and other activities that offer psychosocial support services.

4. Training. Staff turnover due to internal migration and emigration creates a constant need for training. Recruiting and regular training for counselors and healthcare professionals will better ensure quality services.

5. Explore the possibility of enacting national-level policies to recruit émigré Guyanese professionals from the United States and the Caribbean for senior positions.

5. Intermediate Result 4

A crucial part of any effective response to HIV is the provision of care and support to mitigate the effects of infection on people living with HIV/AIDS and to provide for the needs of orphans and vulnerable children affected by AIDS. People living with HIV/AIDS have enormous psychosocial needs, and they and their families have other welfare needs such as economic and nutritional support, and legal advice. In resource-poor settings such as Guyana, families need to provide nursing care at home. Should additional funding become available for antiretroviral therapy, families need to be able to ensure compliance with treatment. When a diagnosis of TB is made, families need to be able to supervise DOTS in conjunction with the health facility team.

Orphans and vulnerable children affected by AIDS also have psychosocial support needs. If the traditional coping methods—sending the children to live with aunts and uncles, or with grandparents—are not practicable, then communities need to be involved in finding foster families who will care for the children and not exploit them. Institutional care is undesirable for many reasons, and children do not learn parenting and homemaking skills in institutions. However, less-desirable are child-headed households or children

dispossessed, destitute, and forced to live on the streets. Thus, intermediate result four contributing to SO3 is: **IR4: Increased use of community-based care and support services.**

USAID/Guyana will monitor and report on the following indicators:

- Number of individuals reached by community and home-based care programs; and
- Number of community and home-based care programs funded by USAID.

Interventions to Achieve IR4

In a broad definition, care and support for people living with HIV/AIDS and their families includes the design and provision of home-based care. This will be achieved through NGOs, CBOs, and FBOs that train family members in hygiene and basic care for people living with HIV/AIDS; training in compliance with antiretroviral therapy, and overseeing TB care in HIV-infected patients. In addition, guidelines and protocols will be developed and links established between the healthcare system, NGOs, home-based care providers, and the community.

USAID/Guyana will use its international experience to work with Guyanese NGOs to support an enlarged NGO participation in care and support, thus supplementing the planned program if funding becomes available through the Global Fund for AIDS, Tuberculosis and Malaria (GFATM). The NGOs currently funded by USAID/Guyana will be encouraged to seek other partners in the community, not necessarily partners in health, who can be enlisted and trained to provide care and support for people living with HIV/AIDS. USAID/Guyana will use any further resources that become available to mobilize and fund NGOs, CBOs, and FBOs to serve as the primary implementers of the proposed GFATM-funded care and support activities. Thus the first intervention to achieve IR4 will result in: **Enhanced capacity for comprehensive community-based response to the needs of people living with HIV/AIDS.**

Illustrative Activities:

1. Capacity building for local NGOs focused on:
    - Care and support for people living with HIV/AIDS. It is important that people living with HIV/AIDS are involved in the planning and implementation of their care and support activities. People living with HIV/AIDS and their families have enormous psychosocial needs, and they must help prioritize and tailor these services to local situations.
    - Community mobilization skills to ensure that CBOs, FBOs, and other local groups are motivated to provide psychosocial care and support, to access legal advice, and to help people living with HIV/AIDS and their families to produce memory books or boxes for their children.
    - Training for trainers so that they in turn can train representatives of CBOs, FBOs, and other groups to help families meet the needs of people living with HIV/AIDS. These include nutritional needs, home nursing care, diarrhea and poor appetite management, and hygiene and infection control.

2. Capacity development for antiretroviral therapy if additional funding becomes available. NGOs will need to work with CBOs, FBOs and other groups to strengthen their ability to assist people living with HIV/AIDS and their families, and encourage compliance with treatment. When a person is diagnosed with TB, NGOs will need to work with the health facility team to assist with DOTS protocols.

Guyana's application to the Global Fund to Fight AIDS, Tuberculosis and Malaria includes a request for assistance to address the needs of orphans and vulnerable children, largely through strengthening the Ministry of Human Services and Social Development. Therefore, USAID will provide technical assistance to the ministry through an international NGO. Because international experience shows that orphans and vulnerable children are best cared for by families in their community, USAID will also work to strengthen the NGOs with which it presently works, and will identify other NGOs, CBOs, and FBOs to spearhead community activities for orphans and vulnerable children and other children affected by AIDS.

A consortium of NGOs will be established to provide training, to recruit new NGO, CBO, and FBO members and local affiliates to coordinate, supervise, and report on member activities. This intervention toward achieving IR4 will have the following result: **Enhanced capacity for a comprehensive community-based response to the needs of orphans and vulnerable children.**

Illustrative Activities:

1. Strengthen the capacity of local NGOs to work with orphans and vulnerable children and other children affected by AIDS. Technical assistance might be include providing training in the psychosocial support needs of children affected by AIDS, particularly if children see many adults in their nuclear and extended families die. Technical assistance might also be provided to increase the ability of local NGOs to mobilize CBOs, FBOs, and other community groups to meet the needs of orphans, vulnerable children, and other children affected by AIDS. CBOs, FBOs, and other community groups must address the stigma associated with AIDS by helping people living with HIV/AIDS make succession plans for the care of their children after their death, for protecting the inheritance of their children, and to ensure their future by continuing in school.

2. If additional funding becomes available to pay for antiretroviral therapy, NGOs will need training in monitoring antiretroviral therapy adherence by seropositive children. Technical assistance might be provided to ensure that parents and guardians who care for seropositive children receive support from local CBOs, FBOs, and other community groups.

USAID/Guyana could support these activities through an international NGO that would partner with local Guyanese NGOs whose work focuses on providing care for orphans, vulnerable children, and other children affected by AIDS.

D. Implementation Modalities

USAID/Guyana now relies on several types of organizations to implement the current HIV/AIDS program. It is likely that many of the current organizational arrangements will continue under the new strategy. However, with an increase in funding, USAID may want to consider bilateral competitive bids for managing large components rather than using the worldwide contracts and cooperative agreements through USAID's Office of HIV/AIDS (OHA). Competitive bidding would give USAID/Guyana more direct control over the work successful bidders and holds the advantage that bidders would be directly responsible to USAID/Guyana rather than OHA. It would also allow USAID/Guyana to better avail itself of local or regional institutions where capacity exists to implement parts of the strategy program. On the other hand, OHA mechanisms are in place to provide technical and program support. With a rapidly expanding portfolio, management responsibilities will increase no matter how the contracting is done.

E. Critical Assumptions and Special Concerns

The successful implementation of the strategy depends on a number of critical assumptions, some based on Government of Guyana actions, and others on USAID actions. Among the most important assumptions are the following:

- HIV/AIDS prevention, treatment, care and support remain priorities for the Government of Guyana and USAID.
- The U.S. Congress continues to appropriate funds for HIV/AIDS.
- Guyana remains one of the 14 countries included in the Presidential Emergency Plan.
- USAID continues to maintain a Mission in Guyana.
- Other development partners are able to meet their commitments, especially CDC for its role in the seroprevalence surveys and the PMTCT and VCT programs.
- The Government of Guyana continues to support and facilitate NGO participation in HIV/AIDS prevention, care and support.
- The Government of Guyana will continue to procure antiretroviral drugs to meet the anticipated rising demands of its AIDS treatment program and will ensure the quality of the drugs produced.
- Coordination among Government of Guyana agencies, donors, and NGOs continues and is made stronger as funding for HIV/AIDS rapidly expands.
- The Ministry of Health and NGOs are able to attract sufficient personnel to implement the growing HIV/AIDS program.
- The follow-on National Strategic Plan in 2006 continues to focus on reaching core transmitters of the virus.

Several special concerns may also affect implementation of the HIV/AIDS strategy. In particular, the Government of Guyana's proposal to the Global Fund for AIDS, Tuberculosis and Malaria requests assistance for an HIV/AIDS program similar to that of USAID. If the Global Fund proposal is approved, government staff and resources are going to be stretched even thinner. It may be necessary to revisit the USAID/Guyana

strategic plan and make necessary modifications. Therefore, flexibility in implementing the strategic plan is called for, especially around the mid-term point of the five-year program.

F. Cross-Cutting Issues

1. Gender

Although the first cases of AIDS were reported in men, there is now evidence that prevalence of HIV infection is increasing in young women, with more cases of AIDS reported in young women than young men aged 15–24 years, in 2001. There are anecdotal reports that young women practice anal intercourse,[60] which increases their vulnerability to HIV infection. Therefore, mass media behavior change communication efforts must segment the messages to address the specific needs of young, sexually active women who may not consider pregnancy as a problem and do not realize their vulnerability to HIV and other sexually transmitted infections. Influential female role models, such as media stars or pageant queens, need to be recruited to speak out about being AIDS-aware and the need to reduce risky behaviors. Interpersonal communication skills for peer counselors should include negotiation skills for safer sexual practices. It is also important that all activities with commercial sex workers address their clients as well.

Because voluntary counseling and testing services in antenatal settings often do not appeal to men, it is important to ensure that such services are available in male-friendly sites for partners of women who accept PMTCT services. PMTCT services should encourage the involvement of their partners to avoid stigma against women and discourage the misconception that PMTCT is a women's issue. Voluntary counseling and testing services must encourage counseling and testing for couples.

2. Stigma

Pervasive stigma associated with HIV/AIDS, often hand-in-hand with denial, must be addressed throughout the USAID/Guyana program. It might be addressed in part in coordination with an SO2 intermediate result associated with transparency.

Denial is evident at the highest levels in government, partly because HIV/AIDS is not being fully addressed by the government as a development issue, and actions to address the epidemic are being left to the direction of the Ministry of Health. Religious leaders and FBOs are not speaking out about personal risk, nor are they being nonjudgmental toward people living with HIV/AIDS. Thus an urgent need exists for community and faith-based organizations to be engaged in addressing stigma. Few people living with HIV/AIDS reveal their status to others. Many who know they are seropositive do not chose to join G+, the NGO that represents people living with HIV/AIDS, because G+ is

[60] Focus group discussions, Industry Village, May 9, 2003.

involved in advocacy and other high-profile activities for the rights of people living with HIV/AIDS. Thus, stigma and denial must be addressed through activities that achieve better policies, coordination, and management.

It will be important to ensure that activities designed to promote risk-reduction practices by the most vulnerable populations do not stigmatize vulnerable people or risk-reduction practices, such as the use of condoms. This can be avoided by ensuring that messages are designed to appeal to the most-at-risk populations, but that they clearly address all sexually active people. Condoms must be made available in places where vulnerable people meet. Condoms must be marketed for all sexually active people, and behavior change communication messages must meet the needs of people who practice anal sex.

Many HIV-positive people present themselves for diagnosis in the late stages of their disease. Little demand for HIV testing exists, and only 67 percent of women offered voluntary counseling and testing through the pilot PMTCT program accept. NGOs report that doctors are not "AIDS-friendly," and the chairman of the Guyana Medical Council reports that private practitioners recommend that patients they diagnose as being HIV-positive seek treatment through the public sector. There are some reports of health facility staff making discriminatory remarks to women who accept PMTCT services.[61] Thus, if prevention and treatment services are to be implemented on a Guyana-wide basis, a need exists to reduce stigma both within the health services and in society in general.

For community-based care and support services to be effective, the local response to HIV/AIDS must acknowledge personal risk and address the issues of denial and stigma.

3. Human Rights

Key among the contextual factors that influence effective HIV prevention, treatment, and care activities is the status of human rights in Guyana. Human rights principles are clearly defined in United Nations documents to which the Government of Guyana is a signatory. These principles, as part of the Guyanese government structure, can help guide the national response to the HIV/AIDS epidemic. When national and local governments, as well as individuals and organizations, recognize and respect the rights of those who are marginalized, including people living with HIV/AIDS, programs for HIV prevention and care can be delivered more efficiently by service providers, and the marginalized groups are more apt to be receptive to the services. Respect for rights translates into more effective prevention and care services.

An effective prevention, treatment, and care strategy, coupled with a stronger awareness of human rights, underscore the need for a multisector HIV/AIDS response. Collaboration by the health and non-health sectors is essential to promote an attitudinal change by governments, communities, and individuals, and to support the policy changes that may be required. Policy advocacy, capacity building, and empowerment by the most

[61] D. Vitalis, 2003.

vulnerable communities and people living with HIV/AIDS can help achieve this objective. Opportunities for collaboration with other USAID/Guyana strategic objectives exist. Civic organizations could become involved in HIV/AIDS prevention, treatment, and care, as well as promoting human rights.

IV. RESULTS AND REPORTING

A. Magnitude and Nature of Expected Results

USAID is dedicated to working with its international and host country partners to reach the most vulnerable groups, including people living with HIV/AIDS, with the best possible prevention, care, and treatment services. USAID recognizes the importance of a shared response to HIV/AIDS. The Mission collaborates with CDC to provide a joint U.S. Government response to the epidemic. U.S. Government efforts combined with other donor and host country partners will allow a comprehensive approach to supporting individuals and communities as they reduce HIV transmission and mitigate the effects of HIV/AIDS.

B. Country Reporting and Performance Indicators and Targets

USAID will report information on three levels: HIV seroprevalence, changes in sexual behavior, and program coverage. National impact and outcome indicators will be reported. Coverage indicators will be reported on a national or program level as appropriate. The reduction of HIV transmission is USAID's most important global health objective. Therefore, the Mission will support the CDC, the Government of Guyana, and other partners to establish and continue a sentinel surveillance system. National seroprevalence will be reported annually. Because Guyana is a low-prevalence country, a special emphasis will be given to seroprevalence among the most-at-risk populations. USAID will collaborate with CDC and the Government of Guyana to ensure that seroprevalence among the most-at-risk populations is collected regularly. The Mission will also work with the Government of Guyana and CDC to collect risk behavior information among the same population groups. The Mission will support a population-based survey to collect information on HIV awareness and risk behaviors in the general population. Finally, the Mission will also report annually on progress toward implementing the HIV/AIDS strategy and increasing the proportion of the population covered by prevention and care programs.

National information that would indicate shared program impact includes HIV seroprevalence for 15- to 24-year-olds, and HIV seroprevalence among commercial sex workers. Seroprevalence rates for other at-risk population groups will also be reported. Risk-reduction indicators that will measure shared program performance are median age at first sex among young men and women, and condom use among commercial sex workers with their last client. Risk-reduction indicators that will be reported but not used

to measure Mission performance are the percentage of the sexually active population with multiple partners, condom use at last risky sexual encounter by the general population, and risk reduction behaviors among those in the most-at-risk population groups.

Progress toward program implementation will also be reported on as a shared response to the epidemic in many program areas. For example, national coverage data for prevention of mother-to-child transmission initiatives is essential. The President's International Mother and Child HIV Prevention Initiative is national in scope, and therefore the Mission will be held accountable for program coverage while recognizing the important role of its implementation partners, including CDC and the Ministry of Health. Conversely, care and support for orphans and vulnerable children is not a programmatic focus of the HIV/AIDS strategy. USAID will institute programs for orphans and vulnerable children in order to support those children affected by HIV/AIDS. However, the magnitude of need is not national in scope, and national-level data are currently unavailable. Therefore, program level data will be reported, but they will not be used to reflect Mission performance. See Table 2 for all performance and reporting indicators.

C. Contribution to International and Expanded Response Goals

USAID/Guyana will contribute to international, expanded response, and Presidential Initiative goals. The Mission recognizes the United Nations General Assembly Special Session on HIV/AIDS and aims to contribute to its international goals. The Mission also contributes to the expanded response targets established in 2001 and the Presidential Initiative goals. The expanded response and Presidential Initiative targets are illustrated below.

Expanded response shared objectives for 2008:

- Reduce prevalence among 15- to 24-year-olds by 50 percent in high-prevalence countries and maintain prevalence below 1 percent among 15- to 19-year-olds in low-prevalence countries;
- Ensure that at least 25 percent of HIV/AIDS-infected pregnant women in high-prevalence countries receive a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission; and
- Enable local institutions to provide basic care and psychosocial support services to at least 25 percent of HIV-infected persons and provide community support services to at least 25 percent of children affected by AIDS in high-prevalence countries.

Presidential Initiative Goals for 2008:

- Prevent 7 million HIV infections;
- Reduce mother-to-child transmission by 40 percent and reach up to 1 million women annually;
- Treat 2 million HIV-infected individuals and care for 10 million HIV-infected individuals and AIDS orphans.

V. RESOURCES

A. Expected Funding Levels

Table 2: Summary of Estimated Expenditures 2004–2008
(All figures in US Dollars)

NOTE: Presidential Initiative funds (noted with *) for prevention of mother-to-child transmission

Component	2004	2005	2006	2007	2008	Total	Percent
Behavior change interventions, including condom social marketing	650,000	730,000	770,000	1,150,000	1,300,000	4,400,000	23%
NGO capacity building	300,000	300,000	350,000	460,000	400,000	1,810,000	10%
Surveillance: Mapping	250,000	0	0	0	0	250,000	6%
Surveillance: DHS	0	300,000	0	0	0	300,000	
Surveillance: BSS	0	0	250,000	0	250,000	500,000	
Care and support	150,000	200,000	400,000	450,000	500,000	1,700,000	9%
Advocacy coordination, multisector	150,000	200,000	200,000	200,000	200,000	950,000	5%
Monitoring and evaluation	115,000*	115,000*	115,000*	115,000*	115,000*	575,000*	6%
	100,000	100,000	100,000	100,000	100,000	500,000	
VCT+	300,000	270,000	330,000	390,000	300,000	1,590,000	8%
PMTCT+	935,000*	935,000*	935,000*	935,000*	985,000*	4,725,000*	25%
Program Management							
JHU Fellow	200,000*	200,000*	200,000*	200,000*	200,000*	1,000,000*	8%
Prog. Ass't, overhead	100,000	100,000	100,000	100,000	100,000	500,000	
Total PMTCT*	1,250,000*	1,250,000*	1,250,000*	1,250,000*	1,300,000*	6,300,000*	
Total Other HIV/AIDS	2,000,000	2,200,000	2,500,000	2,800,000	3,000,000	12,500,000	
GRAND TOTAL	3,250,000	3,450,000	3,750,000	4,050,000	4,300,000	18,800,000	100%

(PMTCT) activities, totaling $6.3 million, are planned for this strategic objective; $2.5 million will be obligated in 2003, and an estimated $3.8 million is to be obligated in FY 2004. However, for comparability in planning with other HIV/AIDS funds, the PMTCT funds are identified on an annual basis, when they will be expended, and not when they will be allocated or obligated. The total figure of $6.3 million is an estimate derived from original guidance and is used for planning purposes.

B. Results with Higher Levels of Support

If additional resources become available, greater access to antiretroviral therapy and care and support for people living with HIV/AIDS would be first priority, especially outside the Georgetown area. This could be achieved by scaling up the genitourinary medicine clinic model at the regional level as well as further expanding community-based outreach through NGOs, CBOs, and FBOs. This kind of outreach would incorporate programs that address the needs of orphans and vulnerable children.

C. Personnel and Management Issues

With the availability of substantial additional funding, USAID will require more supervisory and management capacity. The current HIV/AIDS strategic objective management team consists of one Johns Hopkins University Fellow, one part-time foreign-service national program assistant, and a one-third-time University of Michigan Fellow who is based at the Ministry of Health. The regional USAID office in the Dominican Republic provides program, controller, contract, and administrative support.

USAID staff will have expanded program supervisory responsibilities for monitoring resources, encouraging greater donor participation, and coordinating with the Ministry of Health and other Government of Guyana entities, encouraging HIV/AIDS advocacy among Guyana's leadership, and working with a larger NGO community. Although Guyana is one of the 14 Presidential Initiative countries for HIV/AIDS, it appears unlikely that USAID will be able to add a direct-hire position. Therefore, USAID should consider adding one technical advisor in AIDS and child survival (TAACS) beginning in FY 2004, and one full-time senior foreign-service national. These positions will be required regardless of which implementation modalities are finally selected.

Key management actions and issues to be considered by USAID include:

- Hiring one foreign-service national and one TAACS.
- Determine implementation modalities and either prepare request for proposal/request for application documents or transfer funds to USAID Washington field support.
- Reinforce linkages with other USAID strategic objectives, particularly those for democracy and governance, and economic growth.
- Work with existing cooperating agencies to ensure adequate management capacity for expanded programs, especially the NGO program.
- Solicit participation of the new U.S. ambassador for advocacy at the highest levels of Guyana's political leadership.
- Support the coordination efforts of the National AIDS Programme Secretariat and encourage greater participation by other ministries.
- Assist the Global Fund country coordinating mechanism to ensure effective planning and linking of resources.

BIBLIOGRAPHY

Allen, C. *HIV Infection and HIV Risk Practices Among Female Sex Workers in Georgetown, Guyana*. Georgetown: National AIDS Program, Guyanese Ministry of Health and Red Thread Women's Development Programme, with technical support from CAREC/GTZ; 2000.

Brown, C. *VCT Strategic Approach*. Washington: USAID OHA; 2003.

Burr, C., W. Kitson-Piggot, S. Lewis, E. Lloyd, S. Samiel, W. Slater, and M. Thorley. *PMTCT Program Assessment–Guyana.* Georgetown: 2002.

Camara, B. *20 Years of the HIV/AIDS Epidemic in the Caribbean – A Summary*. Washington: Pan American Health Organization/World Health Organization. Undated.

Carrington, W.J., and E. Detragiache. How Extensive is the Brain Drain? *Finance & Development Magazine* (an IMF publication). June 1999: Vol. 36, No. 2.

Centers for Disease Control and Prevention. *Guyana HIV/AIDS Assessment and Recommendations*. Atlanta: National Center for HIV/STD/TB Prevention and Global AIDS Program; 2001.

_____. *The VCT Curriculum: A Historical Perspective*. Atlanta: CDC. Undated.

_____. *Voluntary Counseling and Testing Activities, Plans and Contact Leads*. Atlanta: National Center for HIV/STD/TB Prevention and Global AIDS Program HIV Prevention Branch. Undated.

Central Intelligence Agency. *The World Factbook 2002, Guyana.* Washington: CIA; 2002.

Edwards, M., O. Nwanyanwu, and W. Slater. *President's International Mother and Child HIV Prevention Initiative Application for Country Initial Program Proposal (IPP)* Unpublished draft report. March 28, 2003.

Family Health International. *Executive Summary for the Youth Study*. Arlington, Virginia: FHI. Undated.

Farrow and Associates, Inc. *Health Infrastructure Assessment, Site Visit Report. June 24–29, 2002*. Prepared for the Humanitarian Assistance Command, U.S. Southern Command; 2002.

Gibbons, A. *The President's International Mother and Child HIV Prevention Initiative*. Implementation Working Group PowerPoint presentation. Washington: USAID OHA; 2003.

Green, E.C., and C. Cortez. *Guyana HIV/AIDS Assessment. The Need for HIV/AIDS Assistance in a Country Without a USAID Health Program*. Washington: The Synergy Project (USAID); 2000.

Guyana Country Coordinating Mechanism. *The Global Fund to Fight AIDS, Tuberculosis and Malaria. Application for Proposals to the Global Fund*. Geneva: GFATM; 2002.

_____. *Draft Proposal to the Global Fund to Fight AIDS Tuberculosis and Malaria.* Georgetown: CCM; May 17, 2003.

Guyana HIV/AIDS/STI Youth Project. *Annual Report* (April 2000–March 2001).

Guyana Responsible Parenthood Association. *Proposal – Guyana STI/HIV/AIDS Youth Project, May 1, 2003–April 30, 2004*. Unpublished proposal; 2003.

Handa, A., C. Antola, G. Castillo, A. Glassman, E. Muhlstein, and S. Raw. *Sector Facility Profile Guyana*. Georgetown: Ministry of Health; 2002.

Handyside, A. *Condom Social Marketing Assessment in Guyana*. Washington: The Synergy Project (USAID); 2002.

Harris, B. *Report on Peer Education Reinforcement, Guyana STI/HIV/AIDS Youth Project*. Arlington, Virginia: FHI; 2002.

Hope Foundation. *Hinterland Outreach Project Grant Proposal, 2003–2004*. Unpublished proposal; 2003.

Hunter, S. *The Universal Framework of Objectives for HIV/AIDS*. Washington: USAID; 1997.

Kangas, L. *Rapid Assessment of USAID's HIV/AIDS Activities and Program Options in Guyana*. Washington: The Synergy Project (USAID); 2002.

Lifeline Counseling Service. *Project Proposal – Scaling up Youth Peer Education, May 2003 to April 2004*. Unpublished proposal; 2003.

Linden Care Foundation. *Project Proposal for Guyana HIV/AIDS & STI Youth Project, May 2003–July 2004*. Unpublished proposal; 2003.

King, G. *Draft Proposal – Programme on HIV/AIDS in Employment*. Georgetown: Ministry of Health and Labour; 2000.

Ministry of Health. *Guyana's National Strategic Plan for HIV/AIDS 2002–2006*. Georgetown: Ministry of Health; 2002a.

_____. *National Health Plan 2003–2007*. Georgetown: Ministry of Health; 2002b.

National Commission on Women. *Issue Paper: Indigenous Women.* November 1997.

OPEC Fund/UNFPA. *OPEC Fund/UNFPA Project For HIV/AIDS Prevention Among 10–24 year olds in Guyana*. 2003.

Palmer, C.J., L. Validum, B. Loeffke, H.E. Laubach, C. Mitchell, R. Cummings, and R.R. Cuadrado. HIV Prevalence in a Gold Mining Camp in the Amazon Region, Guyana. *Emerg Infect Dis.* 2002;8:330–331.

Pan American Health Organization. *Health Systems and Services Profile of Guyana*. 2nd Ed. Washington: PAHO; 2001.

_____. *Voluntary Counselling & Testing (VCT) Initiative*. Washington: PAHO; 1999.

_____. *VCT Policy Paper Background*. Washington: PAHO; 1997.

Pan American Health Organization/Ministry of Health. *Health Sector Analysis Guyana*. Georgetown: PAHO/Ministry of Health; 2002(?).

Persaud, N. *Epidemiology of HIV/AIDS in Guyana.* Georgetown: Ministry of Health Department of Disease Control. Undated.

PHNI Project. *PHNIP Country Health Statistical Report, Guyana*. Washington: PHNI; 2002.

_____. *USAID Country Health Statistical Report, Guyana. Prepared for USAID*. Washington: PHNI; 2003.

Policy Project. *AIDS Program Effort Index.* Washington: The Futures Group; 2000.

Ramsammy, L., F. Colomba, M. Kohut, G. Maynard, A. Alleyene, and C. Singh. *Health Sector Reform* 1999–2004. Undated.

Republic of Guyana. *Level and Flows of Resources in Response to HIV/AIDS, 1999–2002*. (Tables). Undated.

Sami, R. *The USAID Funded HIV/AIDS Youth Programme for Guyana*. *A Report on the Assessment of Eight Guyanese NGOs.* Arlington, Virginia: Family Health International. Undated.

Slater, W., and O. Nwanyanwu. *US Government-Supported HIV/AIDS Activities in Guyana*. Georgetown: USAID and CDC. Undated.

Slater, W., M. Edwards, O. Nwanyanwu, and C. Ruparelia. *Trip Report – Voluntary Counseling and Testing Needs Assessment – Guyana, March 3–7, 2003*. USAID/Guyana Program on HIV/AIDS. Georgetown: USAID/CDC/JHPIEGO; 2003.

Springer, D. *Voluntary Counseling and Testing (VCT) Initiative. 2000 Half Year Report*. Georgetown: Ministry of Health, in collaboration with CAREC-GTZ; 2002.

The Synergy Project. *HIV/AIDS in Guyana and USAID Involvement*. Prepared for USAID; 2003.

UNAIDS. *Report on the global HIV/AIDS epidemic*. Geneva: UNAIDS; 2002.

United Nations Development Programme (UNDP). *Human Development Report 2002*. New York: UNDP; 2002.

United Nations Children's Fund (UNICEF). *The Action Form 2002–2004*. Chart. Georgetown: UNICEF; 2003.

U.S. Agency for International Development (USAID). Annex C: *Special Objective Results Framework—Chart*. Undated.

_____. *Expanded Response Guide to Core Indicators for Monitoring and Reporting on HIV/AIDS Programs.* Washington: USAID Office of HIV/AIDS; 2003.

_____. *Functional Series 200. Programming Policy ADS 200. Introduction to Managing Results*. Washington: USAID; 2003.

_____. *Functional Series 200. Programming Policy ADS 201. Planning*. Washington: USAID; 2003.

_____. *Functional Series 200. Programming Policy ADS 202. Achieving*. Washington: USAID; 2003.

_____. *Functional Series 200. Programming Policy ADS 203. Assessing and Learning*. Washington: USAID; 2003.

_____. *National Strategic Plan for HIV/AIDS 2002–2006*. Revised. Washington: USAID; 2002.

_____. *Performance Monitoring and Evaluation. TIPS. Selecting Performance Indicators. Number 6*. Washington: USAID Center for Development Information and Evaluation; 1996.

_____. *Performance Monitoring and Evaluation. TIPS. Preparing a Performance Monitoring Plan. Number 7*. Washington: USAID Center for Information and Evaluation; 1996.

_____. *Performance Monitoring and Evaluation. TIPS. Establishing Performance Targets. Number 8*. Washington: USAID Center for Information and Evaluation; 1996.

_____. *Performance Monitoring and Evaluation. TIPS. Conducting Focus Group Interviews. Number 10*. Washington: USAID Center for Information and Evaluation; 1996.

_____. *USAID's Expanded Response to HIV/AIDS*. Washington: USAID Bureau of Global Health, Office of HIV/AIDS; 2002.

_____. *USAID Guidance on Performance Measurement*. Washington: USAID. Undated.

USAID/Guyana. *Results Review and Resource Request 2002–2003*. Washington: USAID; 2001.

Vitalis, D. *Summary of a Review of the PMTCT Pilot Program in Guyana*. Presentation at PMTCT Steering Committee Meeting, May 6, 2003. Georgetown: Ministry of Health; 2003.

Volunteer Youth Corps. *Consolidating our Gains, Increasing our Efforts against HIV/AIDS. Grant Proposal for 2003 – 2004*. 2003.

Welford, A. *Stepping Stones: A Training Package on HIV/AIDS, Communication and Relationship Skills.* London: Action Aid; 1995.

World Health Organization. *Guidelines for Second Generation HIV Surveillance*. Geneva: WHO/CDS/CSR/EDC/2000.

ANNEX I: Performance Monitoring Plan

Indicator	Data Source/ Frequency	Partners Reporting	Unit of Measure and Disaggregation	Quality Assurance	Baseline Value/Year	2004 target/ actual	2005 target/ actual	2006 target/ actual	2007 target/ actual	2008 target/ actual
SO: Seroprevalence among commercial sex workers	Behavioral surveillance surveys 2–3 years	Family Health International, University of Guyana, Ministry of Health	Percentage of blood samples taken from commercial sex workers that test positive for HIV during seroprevalence surveys Sex, Age		____(2003)					
SO: Number of HIV-infected women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission	Routine health information system (RHIS) Annually	Ministry of Health	Number of HIV-positive pregnant women receiving nevirapine at delivery Region	Supervision visits/ periodic record quality checks	48 (2002)	100	150	210	270	365
IR1: Median age at first sex among young men and women	Behavioral surveillance surveys 2–3 years	Family Health International, University of Guyana, Ministry of Health	Age by which half of women and men aged 15–24 have had penetrative sex annually (UNAIDS Handbook) Sex, Age		____(2003)					

IR1: Condom use with last client among commercial sex workers	Behavioral surveillance surveys 2–3 years or 5 years?	Family Health International, University of Guyana, Ministry of Health	Percent of commercial sex workers surveyed who report using a condom with their most recent client Sex, Age		____(2003)					
IR1: Number of condoms sold or distributed	Program Reports Annually	Population Services International (PSI), Ministry of Health (MOH)	Number of condoms sold by PSI and/or distributed by the MOH/NGOs in the last 12 months	Periodic record quality checks	____(2002)	1.7m	3.4m	6.8m	13.6m	27.2m
IR2: Number of individuals accepting counseling and testing in the past 12 months	RHIS, Program Reports Annually	Ministry of Health, Nongovernmental organizations	Number of individuals accepting counseling and testing in the past 12 months Region, Sex	Supervision visits/Periodic record quality checks	1,000 (2002) MOH estimate	2,000	3,680	6,992	13,284	20,000
IR2: Number of pregnant women accepting counseling and testing in the past 12 months	RHIS Annually	Ministry of Health	Number of pregnant women accepting counseling and testing in the past 12 months Region	Supervision visits/Periodic record quality checks	3,197 (2002)	4,902	5,814	7,600	9,120	12,825
IR2: Number of HIV-infected patients receiving treatment or prophylaxis for opportunistic infections	RHIS Annually	Ministry of Health	Number of HIV-infected patients receiving treatment or prophylaxis for opportunistic infections in the past 12 months Region, Sex	Supervision visits/Periodic record quality checks	____(2002)					

IR2: Number of USAID-supported health facilities offering PMTCT services	Program Reports Annually	CDC, Ministry of Health	The number of health facilities offering the minimum package of PMTCT services in the past 12 months		8 (2002)	16	20	24	28	32
IR3: Number of individuals reached by home-based care programs in the past 12 months	Program Reports Annually	NGOs	Number of individuals reached by home-based care programs in the past 12 months Region, Sex	Supervision visits/Special Studies	____(2003)	627	700	770	862	962
IR3: Number of community and home-based care programs funded by USAID in the past 12 months	Program Reports Annually	NGOs	Number of community and home-based care programs funded by USAID in the past 12 months Region	Periodic record quality checks	____(2003)	4	6	8	10	12
IR4: AIDS Program Index	Special Study ??Annually??	Policy Project/Futures Group	AIDS Program Effort Index		____(2004)					
Expanded Response Reporting Indicators										
HIV seroprevalence for 15- to 24-year-olds	Antenatal clinic sentinel surveillance survey Annually	CDC, Ministry of Health	Percentage of blood samples taken from women aged 15–24 who test positive for HIV during sentinel surveillance surveys of antenatal clinics Age		____(2003)					

HIV seroprevalence for patients with a sexually transmitted infection	RHIS Annually	Ministry of Health	Percentage of blood samples taken from patients at infectious disease clinics that test positive for HIV every 12 months		____(2002)					
HIV seroprevalence for other most at-risk groups	Behavioral surveillance surveys 2–3 years	Family Health International, University of Guyana, Ministry of Health	Percentage of blood samples taken from participants in seroprevalence surveys targeted to most-at-risk groups		____(2003)					
Percentage of sexually active population with multiple partners	Behavioral surveillance surveys 5 Years	Family Health International, University of Guyana, Ministry of Health	See footnote[62] Sex, Age		____(2003)					
Condom use at last risky sex	Behavioral surveillance surveys 5 years	Family Health International, University of Guyana, Ministry of Health	Percentage of respondents 15–49 who report using a condom the last time they had sex with a nonmarital, noncohabitating partner, of those who have had sex with such a partner in the past year. (USAID Handbook)		____(2003)					
Number of clients who received services at clinics that treat sexually transmitted infections	RHIS Annually	Ministry of Health	Number of persons who receive STI treatment according to national guidelines	Supervision visits/Periodic record quality checks	____(2003)					

[62] For those in a stable relationship (i.e., married or living together): Proportion of respondents (15–49) who have had sex with a nonmarital, noncohabitating partner in the past 12 months of all respondents reporting sexual activity in the past 12 months (*UNAIDS Handbook*). For those not in a stable relationship 0(i.e., married/living together): Of all people surveyed, the percentage of respondents who are not in a stable relationship who have had sex with more than one partner in the past 12 months.

Number of STI clinics with USAID assistance	Program Reports Annually	Ministry of Health	Number of STI clinics with USAID assistance	Supervision visits/Periodic record quality checks						
Number of orphans and other vulnerable children receiving care and support	Program Reports/Special Studies Annually	NGOs	Number of orphans and vulnerable children served by community/home-based care programs during the past 12 months	Supervision visits/Special Studies[63]						
Number of OVC programs with USAID assistance	Program Reports Annually	NGOs, MHSSD	Number of Orphans and Vulnerable Children programs with USAID assistance in the past 12 months	Supervision visits/Periodic record quality checks						
Number of community initiatives or community organizations receiving support to care for orphans or other vulnerable children	Program Reports Annually	NGOs, MHSSD	Number of community initiatives or community organizations receiving support to care for orphans or other vulnerable children in the past 12 months	Supervision visits/Periodic record quality checks						
Number of women who attended PMTCT sites for a new pregnancy in the past 12 months	RHIS Annually	MOH	Number of women who attended Prevention of Mother To Child Transmission sites for a new pregnancy in the past 12 months	Supervision visits/Periodic record quality checks	4,669 (2002)					

[63] Number and percentage of orphans and vulnerable children younger than 18 years whose households received free external support in the last 12 months to care for the child.

Number of women with known HIV-infection among those seen at PMTCT sites with in the past 12 months	RHIS Annually	MOH	Number of women with known HIV-infection among those seen at Prevention of Mother To Child Transmission sites with in the past 12 months	Supervision visits/Periodic record quality checks	124 (2002)					
Number of VCT centers with USAID assistance	Program Reports Annually	NGOs, MOH	Number of voluntary counseling and testing sites funded by USAID in the past 12 months		____(2004)					
Number of HIV-infected persons receiving ARV treatment	RHIS Annually	MOH	Number of individuals with advanced HIV-infection receiving antiretroviral therapy (UNGASS)	Supervision visits/Periodic record quality checks	146 (2002)					
Number of USAID-assisted ARV treatment programs	Program Reports Annually	MOH	Number of antiretroviral treatment program funded by USAID in the past 12 months							

Note: because of the paucity of hard data, all targets should be considered illustrative. They should be reviewed when the baseline is available with the fifth year target guided by any targets set for the President's International Mother and Child HIV Prevention Initiative or agreed internationally.

ANNEX II: Scope of Work
USAID/Guyana's HIV/AIDS Strategic Design for 2004–2008

I. IDENTIFICATION OF THE TECHINCAL ASSISTANCE
USAID/Guyana is developing their new HIV/AIDS Strategic Design for 2004–2008 as part of the Mission's Strategy. The Mission requests The Synergy Project to coordinate the expansion of the existing special objective into a strategic objective and strategic design in line with recent guidance from the Global Health Bureau. Rapid Assessment of USAID's HIV/AIDS Activities and Program Options in Guyana, conducted by Synergy, to would guide concept development for the HIV/AIDS Strategic Design.

II. GENERAL BACKGROUND
The AIDS pandemic has hit the Caribbean harder than anywhere outside sub-Saharan Africa. Guyana has the second highest HIV prevalence in the Caribbean next to Haiti. The general adult population's estimated prevalence is between 3.5–5.5 percent. Transmission is primarily heterosexual (80 percent); 75 percent of infections are attributed to people ages 19–35 years. AIDS now is the third leading cause of death.[64] Sobering as these data are and contrasted with many African countries that have HIV prevalence levels of 25–35 percent, Guyana's infection rate is relatively low, although clearly a generalized epidemic. An aggressive prevention effort mounted now conceivably could hold Guyana's infection level down and reverse the increase in the virus' spread. Knowing what to do is not the main issue; determining how to do it is the challenge.[65]

Reduction of Risk of HIV/AIDS Transmission
A number of donors are currently active in the health sector, and some are already mounting HIV/AIDS activities. The Canadian International Development Agency is working with the Ministry of Health (MOH) to strengthen health management systems. UNICEF works with the MOH on the prevention of mother to child transmission (PMTCT) initiative and also supports some NGO work. Pan American Health Organization provides specialist technical assistance to the MOH, while UNAIDS provides seed money and a forum for activity coordination. CDC has recently begun working in the areas of surveillance, PMTCT, and voluntary counseling and testing, while regional programs provide epidemiological analyses. Finally, a World Bank project has also recently begun in the HIV/AIDS sector.

Due to USAID/Guyana's genuine comparative advantage in the HIV/AIDS area, the Mission recommends that the HIV/AIDS component be upgraded from a Special Objective to a Strategic Objective. This recommendation is based on USAID's nearly three years of experience in Guyana working on the Youth Project and its role as the lead donor in implementing the Risk Reduction Component of the Ministry of Health's HIV/AIDS Strategic Design (2002–2006). The main areas of focus of this component are behavior

[64] Pan American Health Organization, 2001.
[65] L Kangas, 2002.

change communications, condom availability and accessibility and targeted interventions to youth and other high-risk groups.

Although the prevalence rate in Guyana is higher (3.5 to 5.5 percent) than some USAID-classified "intensive focus countries," the relatively fewer number of persons infected gives the Mission a unique opportunity and window to avoid the repetition of the experiences of many African countries where the epidemic has raced ahead virtually out of control. This means, however, that USAID/Guyana and its partners must aggressively pursue preventive interventions with the highest payoff as quickly as possible. The devastating effects of the AIDS epidemic on the future development of a country like Guyana with a relatively small population, but high and growing HIV prevalence cannot be underestimated.

III. OBJECTIVES OF THE ASSIGNMENT

The objective of this assignment is to assist USAID/Guyana in the design of a new HIV/AIDS Strategy Design for 2004 – 2008, as part of the new Mission's strategy for the same period. The HIV/AIDS Strategic Plan will design follow the guidance provided by OHA (Annex 1). The Synergy Project will provide a three-member team to assist in the design. The team will be composed of a team leader, monitoring and evaluation specialist, and behavior change communication specialist with expertise in youth programming and MTCT. The team will work closely with USAID/Guyana staff who will be involved in the design and conduct of the assignment.

The new Mission HIV/AIDS Strategy will consider the following technical areas and their funding:

Guyana Youth HIV/AIDS/STI Youth Project

USAID/Guyana has established a leadership role in Guyana through its Youth Project by rapidly mobilizing nine NGO's to expand awareness and prevention activities among youth in seven of ten regions. Admittedly somewhat labor intensive, but equally necessary, is the collaborative model approach, which supports mobilization and NGO coalition-building activities.

Condom Social Marketing Project

The Condom Social Marketing Project will tap into established peer education networks and will complement this by making condoms more available and accessible. A sustained effort is required to ensure that the desired behavior change is maintained over time. Currently, the Mission's HIV/AIDS program is funded outside of bilateral resources. A shift to bilateral resources, which is requested, will ensure that the project continues through 2008. This will also enable the project to expand its scope from targeting youth to include additional high-risk groups such as men who have sex with men and commercial sex workers. A survey in 1997 indicated a 45 percent HIV prevalence rate among commercial sex workers in Georgetown. The additional resources will also significantly increase the frequency and reach of all marketing and behavior change communication activities. Interventions targeting these additional high-risk groups have been a persistent gap in current programs. They have been identified in the Ministry of Health's new

strategic plan as a priority area under the risk reduction component for which USAID will be taking the lead role.

Programming to reduce Mother to Child Transmission of HIV/AIDS (PMTCT)
PMTCT will be a major focus of the new strategy plan. Guyana is included in the Untied States Presidential Initiative on PMTCT and AIDS Emergency Plan. Although it is a new focus for the strategy design the USAID Mission is working closely with CDC Guyana on this initiative and are in the midst of discussions on how best to move forward.

Expanded Business and Labor Response to HIV/AIDS
The Mission will engage the business and labor community in the fight against HIV/AIDS. The epidemic is already showing signs of impacting the mining industry and affecting its human resources capacity. A 1998 survey of gold miners indicated an HIV prevalence rate of approximately 6 percent. Currently, the business community's response consists mainly of sporadic public education sessions that touch only upon very basic issues. Many agencies such as the National AIDS Programme and a variety of NGOs already provide this service. While many businesses and labor organizations have expressed interest to do more, local technical assistance to guide them through the comprehensive response that a business or labor organization optimally should take does not exist. Funding would allow the mission to assess the situation, identify an implementing partner (e.g., the Academy for Educational Development is implementing similar work in the region), and develop a plan that would increase the capacity of local organizations to provide this needed technical assistance. In addition, it might increase advocacy by the private sector to confront the epidemic. USAID's comparative advantage is based on the existing networks developed through the Mission's Economic Growth and Democracy and Governance Strategic Objectives. These networks will also facilitate the development of a Guyana Business and Labor Coalition on HIV/AIDS.

Strengthen Research
Expanding the scope of our HIV/AIDS program will allow the strengthening of ongoing quantitative and qualitative research, which is the foundation of the expanded project. The Mission will be able to directly measure the success of the project both in terms of increase in comprehensive correct knowledge of HIV/AIDS among targeted groups, perception of risk, intent to change behavior, reduction in number of sexual partners, increase in reported condom use with last non-regular sex partner, delay on onset of first sexual encounter, and total number of condoms sold.

IV. DELIVERABLES

A complete document titled: "Recommendations to USAID/Guyana HIV/AIDS Strategic Design (2004–2008)." The document will be based on Global Health Bureau's guidance for strategies. It will include:

a. An Executive Summary of the Strategy, which could, if necessary, be used as a separate document;
b. A Situation Analysis, which could be used as a separate document.
c. The monitoring and evaluation plan as a part of the HIV/AIDS/STI Strategy, containing appropriate indicators (with gender considerations as appropriate) to

be incorporated in the Results Framework, including baselines and targets through 2008;

d. Budget scenarios by fiscal year (FY04 - 08).

A briefing with the Mission upon arrival and a debriefing with the Mission before leaving the country.

V. METHODOLOGY

In order to examine the issues above, the following methodology should be considered.

1. Review of documents listed below.

2. Participate in a Team Planning Meeting in Washington, DC at the Synergy Offices, prior to field visits. During the Team Planning Meeting the team will review the scope of work and verify methods for completing the detailed tasks and deliverables in the time frame of the consultancy. The team will seek clarity on any issues and negotiate any concerns and changes with the Mission during the Team Planning Meeting.

3. Interviews with key contacts at USAID/Washington.

4. Focus group discussions with stakeholders in three areas: NGO strengthening/youth risk reduction, condom social marketing and business labor response (and others as appropriate).

5. Field visits as appropriate.

6 Interviews and discussions with officers at USAID, collaborating agencies, Ministry of Health and key Guyana counterparts possibly including:

Dr. Mike Sarhan, USAID/Guyana Mission Director
Mr. William Slater, USAID/Guyana HIV/AIDS Advisor
Dr. Leslie Ramsammy, Minister of Health
Dr. Rudolph Cummings, Chief Medical Officer, Ministry of Health
Dr. Morris Edwards, Director, National AIDS Programme, Ministry of Health
Dr. Janice Woolford, Director, Maternal and Child Health Division, Ministry of Health
Major Tyler Fitzgerald, U. S. Military Liaison Officer
Ms. Theresa D. Rubin, U. S. Centers for Disease Control and Prevention, Global AIDS Program

Mr. Godfrey Frank, UNAIDS Country Program Advisor
Dr. Uli Wagner, GTZ/Caribbean Epidemiological Center
Mr. Salim Habayeb, World Bank
Ms. Shiela Samiel, Caribbean Epidemiological Center
Mrs. Williams Mitchell, Caribbean Epidemiological Center
Mr. Paul Nary, Family Health International
Mr. Kenroy Roach, Chairman, Volunteer Youth Corps

Mrs. Hazel Benn, Director, Linden Care Foundation
Mr. Basil Benn, Region 10 Executive Administrator, Region 10
Ms. Gillian Butts, Guyana Responsible Parenthood Association
Mr. Ivor Melville, Hope Foundation, Bartica
Mrs. Shawndella Charles, Comforting Hearts, New Amsterdam
Ms. Simone Sills, Youth Challenge Guyana
Mr. Stephen Sandiford, Canadian International Development Agency
Mr. Jimmy Bhojedat, Lifeline
Mr. Dexter Rowe, Artistes in Direct Support
CDC Guyana working in PMCTC, VCT, surveillance and epidemiological analysis
CDIA working with the MOH to strengthen health management systems
UNICEF Resident Representative (working with the MOH on PMTCT and NGO strengthening)
Pan American Health Organization TA to MOH
World Bank
UNDP
Canadian International Development Agency
European Union
Japan International Cooperation Agency
The Director of Blood Transfusion Services
Regional Health Services Director
The Director of GUM Clinic

And any others identified by the Mission.

6. Draft the recommendations for the strategic plan that would cover results to be achieved, the logic of the causal relations, assumptions to be monitored, illustrative approaches and activities, potential program synergies, performance management plan that includes empirically verifiable candidate indicators and budgetary scenarios for each fiscal year beginning FY 04 ending in FY 08.

7. Review strategic plan with key stakeholders.

8. Complete draft and submit in writing

VI. REFERENCE MATERIALS

USAID:
Concept Paper
Joint PMTCT Assessment
"R 4" Results, Review and Resource Request, 2002–2003
Guidance on the New Monitoring and Evaluation Reporting System Requirements for HIV/AIDS Programs
ADS
R4 Documentation and FY 2003 Indicator Data for Guyana
HIV/AIDS in Guyana and USAID Involvement

HIV/AIDS Youth Program for Guyana: A Report on the Assessment of Eight Guyanese NGOs (Family Health International)
Condom Social Marketing Assessment in Guyana (The Synergy Project)
Guyana HIV/AIDS Assessment: The Need of HIV/AIDS Assistance in a Country Without a USAID Health Program
Special Objective Results Framework
Ready Body Monthly Monitoring Tool

Pan American Health Organization:
Health Systems and Services Profile of Guyana, 2nd edition, December 14, 2002
Country Health Profile 2001: Guyana

Centers for Disease Control and Prevention:
Guyana HIV/AIDS Assessment and Recommendations, July 2001
Country Assistance Plan for Guyana, Plan Period: FY03–FY04, Draft by Theresa D. Rubin, October 1, 2002

Inter-American Development Bank:
Basic Nutrition Program: Sector Facility Profile, Guyana, April 23, 2002

Guyana Ministry of Health:
Health Sector Reform 1999–2004

General:
Report on Peer Education Reinforcement: Guyana STI/HIV/AIDS Youth Project, September 12, 2002
Guyana: National Strategic Plan for HIV/AIDS 2002–2006, July 2002
Global Fund Proposal

And other documents as identified by the Mission.

VII. TEAM COMPOSITION AND DESIRED QUALIFICATIONS

1. Team leader with at least 10 years experience with HIV/AIDS and health and population programming. He/She should be knowledgeable of HIV/AIDS and maternal & child health and family planning & reproductive health program planning and management, with extensive experience in designing of HIV/AIDS/health/population programs and the development and writing of Strategic Designs. Excellent oral and written skills required.

2. Senior program monitoring and evaluation specialist with at least ten years experience in international HIV/AIDS and health and population program monitoring and evaluation. He/She must have state-of-the-art knowledge of recent AID/W directives on monitoring and reporting in the area of HIV/AIDS and the latest information on mandatory HIV/AIDS indicators. Will be the main contributor to the

analysis of the PMP and to recommendations for the development of the monitoring and evaluation plan. Excellent oral and written skills.

3. Senior behavior change specialists with at least 10 years experience with HIV/AIDS program planning and design, with a focus on behavior change communications and information, education and communications. He/She should be knowledgeable in information, education and communications systems and program design and application in HIV/AIDS. Excellent oral and written skills are required.

4. A logistic coordinator experienced in the local setting and able to arrange meetings and site visits with stakeholders.

VIII. REPORTING REQUIREMENTS (Products)

1. The outline for this Strategy Design and a description of what is required in each section is included in Annex 1.
2. All reports should be done using Microsoft products.
3. All drafts will be submitted to the clients and Synergy and be processed through Synergy's technical quality review process.
4. Synergy will edit the situation analysis for general distribution and posting on the USAID and Synergy Project websites. (This last activity will be supported by OHA core funds in Synergy).

IX. RELATIONSHIPS AND RESPONSIBILITIES

The principal contact for this assignment will be Dr. William Slater, HIV/AIDS Technical Advisor, USAID/Guyana.

At the Synergy Project the Technical Backstop is Shelley Smith and the Program Manager is Dorothy Bell.

The team leader will provide oversight to the team and the field preparation of the products of this assignment.

X. PERIOD OF PERFORMANCE

The fieldwork for this assignment will take place between May 3 and May 28, 2003. The duration of the assignment in country is 3 weeks for each of the team members. Additional time will be required in the US by all the team members to prepare for the field visits, and to prepare final written reports. The Synergy Project will require time in the US to complete the final document. A six-day workweek is anticipated for fieldwork in Guyana. The expected timetable for the assignment is:

Activity	Dates	Team Days	Deadline
Mission sends background documents to Synergy			April 1
Synergy distributes background documents to team members			April 15
Consultants read background documentation	April 16–30	2	
Meeting logistics coordinator begins work on organizing focus group meetings and other appointments in Guyana.	May 1–22 (20 days total)		
Briefing in Washington with OHA and others	May 1–2	.5	
Team planning meeting	May 1–2	1.5	
Travel to Guyana	May 3	1	
Briefings with Guyana Mission	May 5	1	
Field work with early focus group meetings and interviews (first week)	May 6–19	12	
Writing in country	May 20–26	6	
Draft report delivered to Mission and Synergy	May 27	.5	May 27
Debriefing	May 27	.5	May 27
Leave country	May 28	1	
OHA debriefing	May 29	1	May 29
Mission and Synergy conduct technical review	May 30–June 13		
All feedback due to Synergy program manager for distribution to team.	June 13		June 13
Team leader revises draft strategy design	June 16–20	3	
Team leader sends final draft to Synergy	June 23		June 23
Synergy prepares final product	July 1–18		
Synergy delivers final product to the Mission	July 21		July 21
Synergy abstracts the situation analysis	July 1–18		
Situation analysis submitted to Mission for review.	July 21		July 21
Mission returns approved version of situation analysis to Synergy	August 4		August 4
Synergy publishes situation analysis	August 29		August 29

XI. LOGISTICS

Administrative support staff from Synergy will be responsible for arranging all travel and communications as well as other eligible expenses associated with the completion of the

assignment. Local expenditures will be the responsibility of the team leader who will be given a budget before his departure. These expenditures may be expected to include travel to site visits to Linden, Bartica and New Amsterdam by team members and some costs for focus group meetings.

XII. FUNDING

This activity will be funded by the USAID Mission through a MAARD to The Synergy Project from FY03 Funds.

ANNEX 1

The Strategic Design Document will address the following primary questions per guidance from GH/OHA in USAID/Washington. See illustrative table of contents in Annex 1.

- What is the situation in Guyana? What is the status of the epidemic? What factors are influencing its growth (or decline)? Who and where are the critical populations to reach with prevention? How many are affected? Which are the current levels of high-risk groups' knowledge, attitudes, practices and behavior that impact on successful HIV/AIDS program implementation? What prior assistance (nature and amount) has USAID provided? What have been the lessons learned from this or other related assistance? What have been the impact/results of prior USAID assistance? Who are USAID's main partners and what are they doing? Is there a national HIV/AIDS strategy? What is the government's commitment to addressing HIV/AIDS and how is this demonstrated? Is there a grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)? What coverage to date have USAID and its partners achieved with prevention, care and support (including for orphans and vulnerable children)?
- What is the proposed USAID strategy? What is the mission's objective? What lower-level results are essential to the achievement of this objective (results framework)? What are the major interventions that the mission intends to support? How are key policy constraints addressed? Do the interventions include activities directed at the most at-risk populations? How is stigma addressed? Are the interventions proposed based on best available evidence? Are people living with HIV/AIDS as well as the most at-risk populations involved in the design and implementation of the program? How are the different needs, perspectives and experiences of men and women addressed? How does the mission strategy respond to the directives and mandates? How do the strategy and the planned assistance relate to the stage of the epidemic, other-partner activities (including GFATM grants), the national strategy, USAID's activities in other sectors and prior USAID experience? How does the mission plan to implement its strategy? Is there flexibility to respond to new information as the state-of-the-art evolves? Which is USAID's comparative advantage in supporting Guatemala's efforts to combat HIV/AIDS/STI?
- What will be the result? What is the nature and magnitude of the change that the mission, with its partners, expects to achieve by the end of the strategy? How will this be measured? What are the key indicators and targets? Are the targets consistent with prior assistance and/or the proposed funding? Will the strategy (mission and partner

assistance) achieve national-level impacts or coverage by reaching a significant proportion of the key populations? How will the mission (and its partners) contribute to the achievement of the Expanded Response international targets (in reducing/maintaining prevalence, PMTCT, access to care and support)? Are the planned investments (USAID and partner) in surveillance, behavior surveys, and monitoring and evaluation sufficient to manage, track and report adequately on the epidemic and the program? How will the program assisted by USAID and its partners build the national capacity to respond to the epidemic? Will the mission, within its span of control, be able to comply with new Agency HIV/AIDS reporting requirements for basic countries? Which are the areas for collaboration between other USAID regional programs? How is the sustainability of the current and planned initiatives?

- What are the resource levels? What are the actual or planned funding and staffing levels? Optional: if additional resources were available, how would these impact on the strategy, program coverage and the expected results? Adequacy of resources currently available to combat HIV/AIDS/STI; Commitment and capacity of other partners, including other donors, in supporting the achievement of the national objectives; Capacity of the implementing agencies to expand or scale-up their current activities;

Illustrative HIV/AIDS/STI Strategic Plan Document Format[66]
Document with tables and annexes should not exceed 50 pages
Table of Contents
List of Acronyms

I. **Executive Summary**, stating main findings, conclusions and strategic recommendations
(not exceeding 3 pages)

II. **Introduction,** describing the purpose of, and the audience for, the assignment and a synopsis of the task (not exceeding 1 page)

III. **Country situation** (background and problem analysis)
- **a.** Current status of the epidemic in Guatemala
- **b.** Needs in prevention, care & support
- **c.** Target populations; host country strategy and actions
- **d.** Extent, lessons learned and results of prior USAID assistance
- **e.** Main partners and their contributions
- **f.** Current program coverage by USAID and partners

IV. **Mission Strategy – rationale, results framework and interventions**
- **a.** Objective (highest level intended result with partners)

[66] Sections III, IV, V, VI and Annex I are required per USAID's July 2002 draft guidelines. "A Collaborative Approach to Review HIV/AIDS Strategies" Annex I.

b. Rationale (basis for selecting objective including country factors, USAID prior experience, resources, comparative advantage and role in relation to host country and other donors)
c. Key intermediate results
d. Critical assumptions
e. Special concerns (e.g., stigma, youth, involvement of people living with HIV/AIDS)
f. Policy environment/constraints
g. Major planned interventions and how these relate to other partner activities including those supported through the Global Fund to Fight AIDS, TB and Malaria
h. Implementation modalities (planned use of bilateral and/or centrally managed grants and contracts)

V. Results and Reporting

a. Magnitude and nature of expected results (USAID and partners)
b. Country reporting and performance indicators and targets
c. Contribution to international and expanded response goals
d. Planned surveillance, surveys and other monitoring and evaluation activities

VI. Resources

a. Expected funding and staffing levels
b. Results with higher levels of support

VII. Annexes

a. Relevant sections of Performance Monitoring Plan
b. Program design scope of work
c. List of persons/consultants interviewed
d. Background supplemental materials useful for a fuller understanding of the report
e. An annotated bibliography of significant documents used or consulted

ANNEX III. List of Contacts

Artistes in Direct Support (A.I.D.S.)
Desiree Edghill, Director
Nazim Hussain

CDC
Okey Nwanyanwu, Director

Canadian International Development Agency
Stephen Sandiford, Program Manager, Enhanced Support to HIV/AIDS in the Caribbean
Violette Pedneault, Health & Population Advisor

Comforting Hearts
Allison Daniels
Shawndelle Charles

DEVTECH
Victorine Lambert, Gender Specialist

Eureka Laboratories
Andrew Boyle, Director

Family Health International
Paul Nary, Senior Technical Officer
Jennifer Shields de Leiva, Program Officer
Jewel Crosse, Local Coordinator
Bonita Harris, Consultant
Natasha Habibullah, Website Developer

Genito-Urinary Medicine Clinic
Michael Ali, Director

Georgetown Public Hospital
Mike Khan, Chief Executive Officer

Guyana Medical Council
Y. M. Bacchus, Chairman

Guyana Responsible Parenthood Association
Gillian Batts-Garnett

Hope Foundation
Rita Brouet
Ivor Melville

Linden Care Foundation
Hazel Maxwell/Benn
Cathy Wilson

Mercy Hospital
Sister Sheila Walsh, CEO
Merisa Rogers, Intern

Ministry of Culture, Youth and Sports
Gail Teixeira, Minister

Ministry of Health
Leslie Ramsammy, Minister
Morris Edwards, Acting Director, NAPS
Curtis LaFleur, Medical Officer (PMTCT, Treatment)
Navindra Persaud, Acting Director, Infectious Disease Control
Frank Anthony, Health Sector Reform Advisor
Donna Carpenter, Consultant for Global Fund proposal
Janice Woolford, Director, Mother and Child Health

Ministry of Labor
Gwen King, Chief Occupational Safety and Health Officer

Network of Guyanese Living with HIV/AIDS (G+)
Shaundell Edwards
Deneen Barrow

Pan American Health Organization/World Health Organization
Bernadette Theodore-Gandi, Representative

Peace Corps
Earl Brown, Director

PSI
John Harris, Country Representative
Shannon England, VCT Program Development Manager

United Nations Children's Fund (UNICEF)
Sree Gururaja, Representative

United Nations Development Programme (UNDP)
Thomas Gass, Deputy Resident Representative
Margot Singh, Communication and Coordination Analyst

United States Embassy, Guyana
Ronald Godard, Ambassador

Major Tyler Fitzgerald, Military Liaison Officer
Ettienne Singleton, Regional Security Officer

USAID/Guyana

Michael E. Sarhan, Mission Director
William Slater, HIV/AIDS Technical Advisor
Chloe Noble, Program Assistant
Jennifer Miller, Adolescent Advisor
Charles Cutshall, Democracy and Governance Advisor

USAID Washington

James Holtaway, Democracy and Governance Advisor

Volunteer Youth Corps

Kenroy Roach
Goldie Scott

Youth Challenge Guyana

Simone Sills
Demitri Nickolson
Jennifer Thomside

Economic Growth Strategic Objective Design Team

Phillip Rourke, Consultant
Martin Weber, Consultant

Democracy and Governance Strategic Objective Design Team

Zerick K. Smith, Senior Research Analyst, Management Systems International
Zoey Breslar, Development Information and Training Specialist, Management Systems International
Paul Nuity
Phyllis Deninio